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Key to abbreviations used:

CB	Children's Bureau.
FLSA	Fair Labor Standards Act.
SSA	Social Security Act.
Per.	Periodical article.
Supp.	Supplement.

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UNITED STATES DEPARTMENT OF LABOR
CHILDREN'S BUREAU
WASHINGTON, D. C.

June 3, 1942
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U. S. GOVERNMENT PRINTING OFFICE 1942

The CHILD
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American Childhood Challenges American Democracy

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Care of Children From Overseas

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Progress Reports –

Maternal and Child-Health Services
Child-Welfare Services

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U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

JULY 1940

THE CHILD

MONTHLY BULLETIN

Volume 5, Number 1 (with Supplement)

July 1940

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THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

The Children's Bureau does not necessarily endorse or assume responsibility for the statements or opinions of contributors not connected with the Bureau.

The Social-Statistics Supplement, issued four times a year, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives THE CHILD.

THE CHILD is sent free on request to a restricted list, including State and local officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to the editor, THE CHILD, Children's Bureau, United States Department of Labor, Washington, D. C.

THE CHILD is for sale by the Superintendent of Documents, Washington, D. C., at $1 a year (single copies, 10 cents each). Postage is additional outside the United States. Subscription orders should be addressed to the Superintendent of Documents, Government Printing Office, Washington, D. C.

• CHILD WELFARE • SOCIAL SERVICES • CHILD GUIDANCE •

American Childhood Challenges American Democracy[1]

By Katharine F. Lenroot
Chief, U. S. Children's Bureau

In his address to the Congress on May 16, 1940, President Roosevelt said:

> I, too, pray for peace—that the ways of aggression and force may be banished from the earth—but I am determined to face the fact realistically that this Nation requires a toughness of moral and physical fiber. Those qualities, I am convinced, the American people hold to a high degree.

Thus spoke the President of the United States in one of the most solemn and fateful hours in the history of the world.

Accomplishments of Our Democracy

Evidence that democracy has toughness of moral and physical fiber has been summarized in the General Report of the White House Conference on Children in a Democracy in these words:

> The present Conference comes after 10 years of economic depression unprecedented in length and of great intensity. A large section of the population was left without income for months or even years. Since the economic soundness of a country underlies a continuance of its freedom, the development of its culture, and the quality of its public services, we might have expected that the decade following 1929 would exhibit the worst conditions ever suffered by the people of this country, and either a retrogression to pioneer hardship or an attempted escape by the way of dictatorship through which some European countries have looked for salvation.

"It is to the everlasting credit of this democracy," the Conference report states, "that despite the strains of the past decade we not only have maintained our social institutions and public services but have notably improved some of them." Among these accomplishments the report cites the fact that basic problems of agriculture, banking, finance, conservation of natural resources, employment, economic security, housing, and long-range economic stabilization have been examined during this period and remedial processes have been set in motion. The health of the Nation has been studied and appraised; medical science has been brought more extensively into public service; public-health administration has been mobilized through local, State, and Federal agencies for steady progress toward building a healthy Nation. Education, recreation, and the problems of youth have been studied on a national scale, and Nation-wide programs for the benefit of youth have been established.

The White House Conference on Children in a Democracy, a great citizens' enterprise in which persons of different political faiths, representing many interests and callings, have worked together with a single aim, affirmed its conviction that—

> . . . . The resiliency of this Commonwealth and its ability to avoid any serious loss of morale under long-continued hardships have proved it to be a stable form of government adaptable to a machine-age civilization and capable of meeting new human needs by democratic methods.

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[1] Paper delivered at National Conference of Social Work, Grand Rapids, Mich., May 28, 1940.

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GOALS FOR THE NEXT DECADE

Clearly, and with complete unanimity, the Conference envisioned the goals of our democracy for the next decade, firm in the belief that we must press forward to achievements "worthy of the freedom and wealth of our Nation." It reported great inequalities throughout the country in the available opportunities for children and youth in rural areas, in low-income groups, among the unemployed, among migrant workers, and in various minority groups. "Honest inquiry," the report points out, "has uncovered conditions unworthy of a democracy with resources like ours and dangerous to its future."

Because this democracy has shown itself bold and capable of dealing with a catastrophic depression without loss of courage or determination, the White House Conference asserts that it feels free to call public attention to the many conditions that still are hazardous to children and to the future of our democracy.

What is the program for the next decade, which the Conference has placed before the American people?

In general, the Conference affirms that the concern of democracy is for every child. It speaks to all the people for all the children. It recognizes the immediate necessity for providing against the material dangers of the moment, but it asserts the equal necessity for maintaining internal strength and confidence among the people of the strongest democracy in the world.

Specifically, the White House Conference calls upon the 29,000,000 families of the Nation to be schools for democratic living. It recognizes that a necessary condition of the family's capacity to serve the child is an income sufficient to provide the essentials of food, clothing, shelter, and health, as well as a home that means for the child, education, happiness, character building. It expresses the determination of the American people that steady progress shall be made toward more complete utilization of our material resources and our manpower, so that by the end of another decade we shall not have to confess that one-half, or even one-third of our children are in families that do not have enough money to provide fully for the essentials of wholesome living. It asserts that the basic economic problem of our children "is the economic problem of the Nation—to find a sound balance of wages, prices, and financing that will provide a growing purchasing power to industrial workers and farmers and profitable investment for capital." It recognizes that "economic aid must continue to be given from public funds to a considerable number of families; that local, State, and Federal government should share the responsibility; and that new, hitherto untried methods may have to be introduced and earlier measures extended."

The Conference sets before the American people the responsibility for correcting a housing situation which condemns many city and rural families to live in shelters unfit for human habitation. Fortunately, the Conference finds, the past decade has been an epoch-making period in the history of housing. It has seen local, State, and Federal governments enter this field, providing housing, especially for low-income groups, to an extent that gives promise of notable achievement.

The Conference recognizes the importance of religion and of opportunity for religious instruction of children and youth in a democracy that seeks to reconcile individual freedom with social unity.

At all times, and particularly in times of crisis, it is true that "the health of the child is the power of the Nation." The Conference affirms that the health and well-being of children depend to a large extent upon the health of all members of their families. Preventive and curative health service and medical care should be made available to the entire population, rural and urban, in all parts of the country, especially to mothers and children, through private resources and general tax funds, or through social-insurance systems, or through a combination of these methods.

Regarding education the Conference recognizes that a primary responsibility of our democracy is to establish and maintain that fair educational opportunity to which every American child is entitled. It holds that—

> The content of education should deal with the personal, social, and economic issues of the day; its

method should take account of scientific discoveries in child growth, child care, and the learning process. And the management of the educational services should seek always to combine maximum efficiency with the requirements of individual initiative and freedom.

The Conference asserts that the development of recreation and the constructive use of leisure time should be recognized as a public responsibility on a par with responsibility for education and health. Private agencies should continue to contribute facilities, experimentation, and channels for participation by volunteers.

Prevention of the exploitation of children and youth in premature and harmful labor must be accompanied by provision for educational training, open to all children, during the years thus left free from wage earning.

As to vocational opportunity for youth the Conference affirms that the situation calls urgently for action and believes that the cost of constructive programs will be less than the ultimate cost of neglect.

The Conference holds that social services to children whose home conditions or individual difficulties require special attention should be provided in every county or other appropriate area and that an obligation rests upon both public and private agencies for the development of adequate resources and standards of service.

Special consideration was given by the Conference to problems of migrant families. It holds that their problems are national in scope and that the Federal Government must accept responsibility for the development of an inclusive plan for their care, assuming full financial responsibility for interstate migrants.

The Conference asserts that the effort to obtain equality of opportunity for children without regard to race, color, or creed should be pursued in the places and institutions that have potentially the greatest influence upon children. The first of these is the family; the second, the school. The Conference recommends that civic and social agencies, labor and consumer organizations, political parties and government agencies not only should place no obstacles in the way of adequate representation and participation of minority groups both in the ranks and in administrative and policy-making activities but should welcome and encourage such participation.

Questions of public administration and finance underlie many of the recommendations of the Conference. It finds that the number of local administrative units of government for health, education, and welfare should be reduced; that financial responsibility should be shared by governments at the various levels, taking into account the needs in the respective localities and States and the resources of these governmental units; and that merit systems which will assure competent personnel in public administration to perform the services essential for children should be adopted in local, State, and Federal governments.

This program of action for the children of our United States is a program for the next 10 years and some of it for a longer period. The Conference believes that its proposals are well within the capacities of the American people and that the economic resources of the country will be enhanced by them. It looks forward to a follow-up program under the leadership of a National Citizens Committee and State organizations, which will reach into every local community, thus helping to make the recommendations a reality in the lives of children.

The very existence of the White House Conference on Children in a Democracy, its ability to formulate a program under government auspices, but through committee and conference action free from government domination, is proof both of our freedom and of the sensitiveness of our democracy to human values.

The history of the United States Children's Bureau, established 28 years ago as the first government bureau in the world devoted to the interests of childhood, is another proof of this freedom and this awareness. Never in the history of the Children's Bureau, whether a Republican or a Democratic administration was in power, has any question been asked of the political opinions of its Chief or any member of its staff. Never has it been hindered from making impartial studies of conditions affecting the welfare of children. Under the merit-system provisions of the Social Security Act the same freedom is being won for State agencies cooperating with the Federal Government in unswerving attempts to bring to more complete fruition the ideals and principles that underlie democracy.

AIMS OF A TOTALITARIAN STATE FOR ITS CHILDREN

Let us examine the aims of a totalitarian government for its children and the extent to which those who serve childhood in a country with such a government are free to promote the values inherent in human personality.

Services for public health and child welfare have been extended in totalitarian states, but the avowed purpose of these activities in Germany has been to train the younger generation in accordance with the views which are essential for the unity of the people: training for the personal development of the individual is to be considered secondary. All preventive and curative health work is considered from the point of view that expenditures should be made for an individual who is physically or mentally sick only in accordance with his value to the whole community. Immediate shift in emphasis from governmental social-welfare work to that done by agencies of the National Socialist Party and from paid to volunteer service characterized the first year of the National Socialist regime. A ministerial circular[2] ordered the removal of women social workers who "because of their personalities could not serve the National State."

Of the seven private child-welfare agencies national in scope, four were either dissolved or combined with others in 1933. The welfare agencies which conformed to the National Socialist ideology were allowed to remain. Admission to reorganized schools of social work was open only to approved members of the National Socialist Party who met certain qualifications. On local child-welfare committees, later abolished, representatives of Hitler Youth and the National Socialist People's Welfare replaced members who formerly had been named by child-welfare agencies.

Responsibility for relief and welfare work was placed in an office of the National Socialist Party. The guiding principle, as given in the order creating this office, was the welfare of the people as a whole in preference to the welfare of the individual. Only those persons were to be appointed to carry on child-welfare work whose opinions conformed to the National Socialist ideology.

These concepts of the relation between the individual and the State and the duty of the State toward the individual stand in sharp contrast to the aims and accomplishments of the Scandinavian nations for their people; to the doctrines of the French philosophers; to the liberties of England; and to the Declaration of Independence and the Constitution of the United States. That democratic principles are still far from complete realization in countries committed to bills of rights and to representative government, social workers would be the first to affirm. That the relentless drive of the German forces has thrown into mortal combat the impersonality and ruthlessness of the machine and the freedom of the human spirit, social workers will be the last to deny.

OUR GOALS FOR CHILDHOOD CHALLENGE OUR DEMOCRACY

The White House Conference on Children in a Democracy last January foresaw many of the issues which would determine the success or the failure of the American people to reach our goals for children in the decade upon which we have just entered. It recognized that the aims of democracy for its children challenge the capacity of American citizens to place the democratic purpose at the center of personal, family, and community life. It understood that the aims of democracy for its children challenge the capacity of the people of the United States so to regulate the economic system as to assure its contribution to the democratic ideal. It saw that the machine must be made to serve man, not man the machine. It realized clearly that the aims of democracy for its children challenge the capacity of American citizens to use government for the advancement of human welfare. It was firm in its belief that we, the American people, would meet these challenges and would make substantial advance toward our goals for childhood in the next 10 years.

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[2] *Zentralblatt für Jugendrecht,* vol. 25, 1933–34, p. 328.

The Conference did not foresee so clearly the extent to which its ends would have to be sought under conditions that challenge the very survival of democracy in any part of the world.

Safeguarding Childhood in the Present Crisis

The United States is now confronted by a world situation which makes it imperative for our people to strengthen all our resources of bodily health, moral fiber, social justice, and spiritual power; to mobilize our industrial and scientific resources; and to augment our military strength in preparation for whatever threats to the continuance of our democratic civilization we may have to meet and whatever responsibilities for maintaining a world order in which free peoples can survive we may have to assume.

What, then, is our duty to the children of today, the citizens of tomorrow, in this time of crisis?

First, it is to understand clearly that our internal strength, our unity of purpose, our effectiveness in achieving results, whether in peace or in war, depend to a great extent upon the confidence with which parents can face the future for their children. Their safety, their health, their homes, and their schools must be protected at whatever cost of resourceful planning and financial sacrifice. The responsibility for such planning rests with all the people, but they must act chiefly through government. Government, in turn, must work in full cooperation with the citizens of the country in their many organizations devoted to civic advancement and human welfare. The follow-up organization of the White House Conference on Children in a Democracy should afford a valuable channel for citizen participation in promoting the health and security of children and interpreting to all the people the needs of children and youth. Citizens must realize that they cannot divest themselves of responsibility by looking to government for the solution of their problems. Government—local, State, or Federal—is only an institution through which citizens act in fulfillment of their obligations to themselves, their families, and their fellowmen.

Second, there must be immediate expression of the purpose of the people of the United States to preserve and strengthen the economic foundations of home life. President Roosevelt's determination to preserve the social gains of the last decade, including governmental action to protect fair labor standards, should receive universal support. Work Projects Administration employment must be maintained in the degree required to provide work for the unemployed. At the same time, general-assistance programs must be strengthened throughout the Nation. Plans for allotments and allowances for families of members of the armed forces similar to those provided under the War Risk Insurance Act should be developed in advance of possible extensive military mobilization.

Third, child-labor standards must be preserved and strengthened. The manpower of the Nation is more than sufficient to meet all needs without calling upon children to sacrifice their strength and their schooling for industrial employment. We must press forward to extend to child workers in industrialized agriculture safeguards similar to those now afforded to children in factory employment.

Fourth, educational resources must be maintained and augmented as necessary to assure to every child a fair chance for schooling throughout the school-age period.

Fifth, the objectives of the Nation for its youth, as they have been expressed in our developing youth programs, must not be forgotten as our young people are drawn into emergency training programs, aircraft production and operation, the manning of war industries, or enlistment in the armed forces. Every facility must be provided for guidance of youth, for encouragement of those with special gifts, for assuring to all youth opportunity for education or useful employment.

Sixth, we must cover the entire Nation as soon as possible with basic public-health and child-welfare services, needed at all times and especially necessary in times of special stress. All the counties, not merely two-thirds of them, should have public-health-nursing service to guard against epidemics, give health supervision, and assist in the development of community health services for children. Medical-care programs for mothers and children should be extended. All our rural counties, not merely 500 of them, should have as soon as possible the services of a child-welfare worker, free from the heavy case loads which are carried by public-assistance workers, and able to give full cooperation to citizens' groups in developing whatever community programs may be necessary to safeguard the health and well-being of children. In every city the public and private resources for safeguarding the health and welfare of children should be reviewed and strengthened with a view to meeting the needs of every child who may require special service.

Seventh, these services to children and youth must be financed in ways that will not interfere with necessary appropriations for military preparedness. The American people cannot afford *not* to spend whatever sums may be required to provide both internal and external security. Financial sacrifices that will be required to meet new obligations must not be asked of families whose incomes are now below the level required to provide the essentials of home life for children. All citizens whose incomes are above this level must be prepared to make any financial sacrifice that may be necessary to preserve and strengthen our democracy.

Eighth, our plans must not be thought of in terms of emergency alone, for unsettled and difficult conditions will challenge our best and most sacrificial effort for at least the next 10 years and perhaps for generations. On the foundations which we now build will depend the kind of superstructure which the White House Conference of 1950 will help to design.

This crisis is a totalitarian crisis, not only for the German State but also for the democracies. That is, our objectives for economic and social justice and for personal freedom cannot be divorced from our objectives for world peace. It is a single challenge which in this year 1940 is placed before the adults, the youth, and the children of the United States and before all the nations of the Western Hemisphere. We cannot be democrats in our sympathies abroad and deny the application of democratic principles to any individual or group of individuals at home. Neither can we be democrats at home and be indifferent to the issues of the terrible conflicts that threaten a complete blackout of human freedom in other lands.

At home we must be concerned about the abolition of all economic barriers to the full use of suffrage; the preservation of civil liberties; the upholding of fair wages and conditions of employment; the assurance to all the people of the United States of a chance to earn a living, of care in illness, of an education, of affection and security in home and community relationships. And in a world where the destruction or impairment of freedom anywhere threatens the freedom of all peoples, we must also accept the responsibilities of world citizenship.

DEMOCRACY AND FREEDOM

Democracy rests upon the freedom of the spirit of men and women and upon the inculcation in children of devotion to the principles of a free civilization. Social work is committed to the freedom and the worth of the human personality, to the cooperation of free people in the pursuit of common ends. The spirit that is truly free may know anxiety, pity, heartbreak, but it does not know fear. Who ever saw fear on the face of Jane Addams? The dictator conquers through the spread of fear. The strength of the free spirit comes from within and cannot be destroyed by external events, however terrible. Democracy rests upon the united purpose of free citizens to defend at all times and in all circumstances the right of free men and women to live and to rear their children in a society where justice and honor, dignity and truth are the guides of individual and civic action.

Planning for Care of Children From Overseas Seeking Refuge in the United States

Children from the war zones may now be admitted to the United States under either quota or visitors' visas under a plan approved by the President of the United States and by the Departments of State and Justice. Preparations for the reception and care of children from the British Isles are going forward.

British Scheme for the Overseas Evacuation of Children.

An Interdepartmental Committee on the Reception of Children Overseas has been set up in the United Kingdom under the chairmanship of Geoffrey Shakespeare, Under Secretary for the Dominions. The Children's Overseas Reception Scheme, worked out by this Committee, is confined for the present to school children who are at least 5 years of age and who are not yet 16. It includes arrangements for children of other nationalities living in Great Britain.[1]

According to the evacuation scheme the British Government would meet transportation costs for the children to the point of debarkation. Parents contribute toward the cost of transportation if able to do so. Private arrangements by parents who are able to meet the full expense are encouraged.

On July 12 the Ministry of Information announced that the British Government has postponed the scheme for the present, because of reluctance to take the responsibility of sending shiploads of children across the Atlantic Ocean without convoy, but that "children sent apart from the Government scheme will be allowed to leave either at the parent's risk or at the risk of voluntary associations which are arranging for their transport."

Admission Procedure.

The Department of Justice and the Department of State announced on July 14 the adoption of simplified procedure which will make possible the admission of children from the war zones in whatever numbers shipping facilities and private assurances of support will permit.

It is contemplated that visas and the necessary travel papers shall at all times during the period of the emergency be in the hands of at least 10,000 children in excess of those for whom shipping facilities are currently available. The plan is designed to facilitate evacuation of children regardless of their financial circumstances.

The new regulation adopted by the Commissioner of Immigration and Naturalization with the approval of the Attorney General provides that alien children under 16 years of age who seek to enter the United States to be safe from the dangers of war may be admitted for a period of 2 years when presenting visitors' visas and when otherwise admissible under the rule and other applicable provisions. The period may be shortened or extended by the Attorney General. They may also be admitted under regular quota visas, which permit an indefinite stay. When presenting visitors' or quota visas, the children shall not be excludable on the ground that they are not accompanied by nor coming to one or both parents, nor on the ground that their tickets or passage have been paid for by a corporation, association, society, municipality, or foreign government or by a nonprofit corporation.

Children are to be admitted under the rule only when the following conditions are met:

> That a corporation not for profit organized for the purpose of assuring the care and support of refugee children, and approved by the Attorney General for such purpose, has given the Attorney General, with such supporting evidence as he may require and in such form as he may require, the following assurances: First, that

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[1] Interdepartmental Committee on the Reception of Children Overseas—Report presented by the Secretary of State for Dominion Affairs, and the Minister of Health, to Parliament by Command of His Majesty, June 1940.

an identified child or a child for whom provision for identification has been or will be made will not become a public charge; second, that arrangements have been or will be made for the reception and placement of such child in accordance with the standards of the Children's Bureau of the Department of Labor; and third, that the sum of $50 for each such child has been or, upon the initial placement of the child, will be deposited in a trust fund established by and to be used by the corporation to meet all contingencies, not otherwise met or provided for, arising after such initial placement respecting either the care of the child while in the United States or its departure therefrom. Every corporation approved by the Attorney General to act under the provisions of this rule shall furnish the Attorney General with an affidavit containing an undertaking that the children admitted * * * will be under continuous supervision [during the period of their stay in the country if presenting visitors' visas, or until they have reached the age of 18 years and for such further period as the Attorney General may require if presenting quota visas], assuring that they are in proper custody and are being cared for in conformity with the standards of the Children's Bureau of the Department of Labor, and a further undertaking to comply with such directions as the Attorney General shall make respecting the admission, care, and support [and in the case of those presenting visitors' visas, the departure] of the children.

Standards of Care.

General standards for child-caring organizations were prescribed by the Children's Bureau on June 28, 1940, as follows:

1. The agency should be approved by and under the supervision of the State department of welfare of the State in which it is located.
2. The agency should be fully qualified and equipped for child-placing service or can be so equipped under plans worked out with the United States Committee for the Care of European Children. The resources of the agency should include a well-organized and professionally staffed social-service department for the selection of foster homes and the continuing supervision of care given to children in such homes.
3. The agency should maintain records of all available information concerning each child and his family and complete reports of care given by the agency.
4. Temporary reception care, if provided, should be in conformity with standards acceptable to the Children's Bureau of the Department of Labor.
5. All European children received for care should be placed in family homes of their own religious faith, immediately or after a brief period of reception care, except when the child's special needs require other forms of care.
6. European children received for care should be assured adequate medical care and health supervision, should attend school until at least the age of 16 years, and should not be gainfully employed prior to the age of 16 years.
7. Not more than two unrelated children should be placed in one home.
8. The agency should retain responsibility for each child until he reaches the age of at least 18 years or has been returned to a parent or legal guardian or transferred to other care with the approval of the United States Committee for the Care of European Children.
9. The agency should agree that the Children's Bureau shall at all times have access to all premises and facilities used for the care of childen and to records of such children.
10. The agency should agree to make such periodic reports of the whereabouts, status, and care of the children as may be prescribed by the Children's Bureau.

Other standards relative to home and reception care are being drafted.

The United States Committee for the Care of European Children.

In order to coordinate the efforts of the many organizations in the United States which are interested in providing care for children from overseas meetings were held in New York on June 19 and 20, 1940, under the chairmanship of Mrs. Franklin D. Roosevelt. As an outgrowth of these meetings the United States Committee for the Care of European Children was incorporated, with headquarters at 215 Fourth Avenue, New York.

The corporation has the following officers: Mrs. Franklin D. Roosevelt, honorary president; Marshall Field, president; Jackson Martindell, treasurer; Agnes K. Inglis, secretary. Eric H. Biddle is executive director. The general work of the corporation is under the direction of an administrative committee with Marshall Field as chairman.

In order to provide the necessary funds the National Child Refugee Committee, with Marshall Field as chairman, is undertaking a campaign, approved by the President of the United States, to raise $5,000,000.

The general purpose of this corporation is to coordinate all available resources for the care of child victims of the war in Europe. Its immediate task is to provide care for children from the British Isles, including children from continental countries who are now in Great Britain seeking refuge. The committee is working in close cooperation with the Departments of State and Justice, the Children's Bureau of the United States Department of Labor, and the Public Health Service. Cooperation of the United States Office of Education has also been assured.

Among other agencies cooperating with the United States Committee for the Care of European Children are the following: American Red Cross; Community Chests and Councils; Child Welfare League of America; National Catholic Welfare Conference; American Public Welfare Association; Council of State Public Assistance and Welfare Administrators; English Speaking Union; International Migration Service; Family Welfare Association of America; National Travelers' Aid Association; and State and local child-welfare organizations. The committee has been designated by the British authorities as the sole committee with whom they will deal in cooperating with the placement of children arriving in this country from the British Isles.

Responsibility for the placement and supervision of children in conformity with the standards of the Children's Bureau will be allocated by the committee to child-caring agencies designated by the Children's Bureau, in consultation with State welfare departments, as equipped to give such service.

Dissemination locally of information from the central committee and coordination of the work of local public and voluntary agencies for children from war zones are being handled by local information committees appointed by the United States Committee. These local committees, which will be closely in touch with the State welfare departments, have now been appointed in more than 150 cities throughout the United States.

FOUNDATION REPORTS

Rockefeller Foundation Raymond B. Fosdick, President of the Rockefeller Foundation, in his review of work in 1939 states that grants were made by the Rockefeller Foundation amounting to a total of about $9,500,000 for the year. The four fields of public health and medical, social, and natural sciences received about $2,000,000 each.

Dr. Fosdick discusses the consequences for scientific research that might result from "war-exhaustion or chaos" in Europe, where the Rockefeller Foundation had 110 appropriations running on the first of September 1939—in Great Britain, Switzerland, France, Sweden.

In describing the status of the various sciences in 1939 and the work carried on in them with the help of the Rockefeller Foundation Dr. Fosdick finds that the scientific process is especially threatened in the social field by the world situation.

The Rockefeller Foundation; a review for 1939, by Raymond B. Fosdick. Rockefeller Foundation, 49 West Forty-ninth St., New York.

Milbank Memorial Fund Thirty-five years in review is the theme of a recent report of the Milbank Memorial Fund. During this time the fund has aided some 169 public and private health and welfare agencies and has expended a total of $11,550,093.88 in grants. The work of the fund is discussed in the fields of population, housing, nutrition, regional health planning, and venereal disease.

The fund's work falls naturally into three periods: A period of exploration, from 1905 to 1921; a period of demonstration, from 1921 to 1930; and a third period, the keynote of which is measurement. The purposes of this measurement are to adapt health work more closely to actual conditions, to demonstrate the need for extending the health program to include the new problems which are arising, and to reveal the weakness of practices which have outlived their usefulness.

Thirty-five Years in Review. Milbank Memorial Fund, 40 Wall St., New York, 1940. 75 pp.

Summary of Progress Report on Child-Welfare Services Under Title V, Part 3, of the Social Security Act

March 4, 1940

By Mary Irene Atkinson

Director, Child Welfare Division, Children's Bureau

At the present time 47 States, the District of Columbia, Hawaii, and Alaska are cooperating with the Children's Bureau in the administration of child-welfare services. Puerto Rico, which was included in the amendment to the Social Security Act passed last August, is in the process of preparing a plan. The one State with which the Children's Bureau does not have a cooperative relationship at the present time is Maine, where the program was suspended as of December 31, 1939.[1]

An annual appropriation of $1,510,000 is available to the States for expenditure each year, plus any unexpended balances from allotments for the 2 previous years. Money is allotted to the States on the basis of a flat grant of $10,000 to each State, plus an amount based on the ratio of the rural population in the State to the total rural population of the United States. The total amount available for expenditure by the States during the fiscal year ended June 30, 1939, was $2,521,942. Of this amount, $1,537,087 was expended during the year, leaving a balance of $984,855 available. This balance was less than that remaining at the end of any previous fiscal year. Plans approved for the fiscal year 1940 include budgets amounting to $2,065,744. These figures indicate that there has been consistent development within the States cooperating in the child-welfare-services program in the acceptance of the philosophy that services for children are an integral part of a public-welfare program.

Personnel resources and funds available to implement services in local areas have been developed to the point where the maximum amounts of Federal money available to the States can probably be expended efficiently during the coming fiscal year.

Under this program, as of October 1, 1939, 394 child-welfare workers in approximately 500 counties or other local areas were employed under local welfare officials or under the State welfare departments. In addition, 51 workers in 8 States were giving some case-work service to children in districts covering a number of counties as part of their work in developing interest in the employment of a local child-welfare worker and in participation in a general child-welfare program.

In 1936, 27 States had administrative divisions within the department of public welfare in which were placed definite responsibilities for direction and leadership of programs affecting children. There are now 40 States in which there are either child-welfare bureaus or child-welfare divisions within departments of public welfare. This development is in line with the principles stated in the report on Social Services for Children prepared by one of the committees of the White House Conference on Children in a Democracy. The statement in the White House Conference report is as follows:

> Social services for children should be developed in relation to other aspects of the State welfare program, particularly the administration of public assistance and relief. Each State in its welfare agency should have a division responsible for promoting the interests and welfare of children with definite appropriation for this purpose. * * * The child-welfare division represents the broad interests of the State in children needing social protection and care.

Recent Trends

The plans for child-welfare services approved for the fiscal year 1940 reflect two trends of particular importance. One is the trend toward further localization of responsibility for the care and protection of children. The fact that Federal funds for child-welfare services are available not only for extending and strengthening State services but also for paying part of the cost of district and local services has stimulated the development of resources for the care and protection of children where they live, and makes this provision of the Social Security Act one of the landmarks in the evolution of services to children. Some States which developed their first plans for child-welfare services on the basis of districts, in this year's plan use the county as the unit of local service. Out of their experience they have learned that there is a limit to the coverage which can be provided by a local worker and that, if the area to which she is assigned is too large, she cannot actually render case-work service of high quality.

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[1] The child-welfare-service program was resumed in Maine on April 1, 1940.

Another significant trend is the evidence of increased investment by some States and local communities in services for children under the stimulation of a cooperative child-welfare demonstration made possible by Federal funds. For example, one State is providing all the funds for supervision and consultation from the State to the local units, leaving the Federal funds to be used for (*a*) the operation of a training unit to which workers may be sent for orientation and for more intensive supervision than is possible in the county units and (*b*) further expansion of local personnel.

The broad language of title V, part 3, of the Social Security Act, together with the liberal philosophy of the Children's Bureau as to the nature of services for children, have resulted in a flexible interpretation of the type of services that may be performed by workers paid in whole or in part from Federal funds. Thus the plans developed jointly by the State agencies and the Children's Bureau continue to be different even though they all conform to the provisions of the act. States which previously had provided both State and local services to children have fitted the Federal funds made available to them into an administrative pattern quite different from that of the States where previously there had been no State provision for social services to children, as, for example, Mississippi and Nevada.

In the States which had already included services to children as part of the public-welfare program the Federal funds have been used to improve the quality of services already established. In the States which were "starting from scratch" funds have been used to help officials and citizens gain some insight into the State's condition relative to child care and protection, and to take the first steps in setting up an administrative structure for service. Through this structure State and local cooperation is stimulated to meet the needs revealed through the initial evaluation. This process has, in some instances, resulted in what appears to have been a slowing up of the development of actual services. However, the value of laying a foundation before a superstructure is erected has been sufficiently demonstrated.

At the beginning of the program there was no formal system for reporting on numbers of children in local areas receiving service from workers paid in whole or in part from Federal funds. Instead, the Assistant Director of the Child Welfare Division of the Children's Bureau explored what the States had been doing and prepared tentative reporting forms and then asked that the States experiment with them. The experience gained in this exploratory period has now been utilized by the Division of Statistical Research of the Children's Bureau. As of January 1940 forms were sent to the States by that Division for formal reports on numbers of children receiving case-work services through workers paid in whole or in part from Federal funds.

The services of the special consultant on Negro child-welfare problems have been made available to States for initiating local services for Negro children; for studying institutional care for Negro children; and for further interpreting the program and developing interest in local and State groups having some concern with the care and protection of Negro children.

Professional Training

In contacts with the States emphasis has been placed on the importance of professional training for workers and of a high quality of supervision for persons already on the job. Thus, in the development of plans a majority of the States have provided for educational leave to enable a limited number of staff members to attend a school of social work and also for the strengthening of supervisory service within the agency. In the majority of States competent personnel is recognized as the basis for service of high quality to children and families. The skills demanded by child-welfare workers are appreciated, and the objectives and purposes basic to all case-work methods are understood. There is also an increasing recognition that certain combinations of characteristics are necessary for a person practicing social case work. It is necessary to select personnel having a knowledge of the accumulated experience of the past, the skill and judgment essential to improve and develop local resources and flexibility in using resources, and an attitude of tolerance, of understanding of the individual and his family, and of faith in his possibility of development.

The plans for child-welfare services for the fiscal year 1940 as submitted by the States include provision for educational leave for approximately 160 workers. The amount of Federal funds available for educational leave may not exceed $110 per month. In many instances a smaller amount has been provided, and it is the responsibility of State officials to determine how much each person who is granted educational leave shall receive. In the statement of policies issued by the Children's Bureau the importance of determining the amount to be granted to an individual on a case-work basis has been stressed. For the fiscal year 1940 the States budgeted $78,039 for educational leave. The length of leave is for one semester or two quarters at least, and in many instances it has been for three quarters or for the school year.

In addition to provision for educational leave and competent supervision a few of the States have established local training units within the regular local public-welfare units. These training units are used as reservoirs for selection of potential workers for educational leave or for orientation of new workers to the program. In five States schools of social work and State agencies have entered into a cooperative arrangement, which permits the local unit to accept for field work students who give promise of fitting into a rural child-welfare program. The supervisor of the training unit is a member of the child-welfare staff of the State department of public welfare and works closely with the school's supervisor of field work. Federal funds may be used to pay salaries of supervisors of field work who are functioning as members of the local staff and are administratively responsible to public-welfare officials, but, of course, these Federal funds cannot be used to pay salaries of faculty members employed by the school to supervise students on a field-work assignment.

Merit System

Recent developments in initiating merit systems in State departments of health and State departments of public welfare have been outlined elsewhere. The Children's Bureau has not, thus far, issued minimum personnel requirements for child-welfare personnel. However, in the plans developed jointly by the State agency and the Children's Bureau, personnel standards have been included. Through a process of negotiation it has been possible to obtain fairly general acceptance of the philosophy that child welfare is a specialized form of social service. Child-welfare services have, therefore, been predicated upon a personnel plan which insures qualified workers in every position, since planning with skill and judgment is the primary aim of the service. In formulating merit systems in the States where previously there has been neither a formal merit plan nor a civil-service system, the standards of personnel now in effect for child-welfare workers have been used, to a large extent, as the basis for writing personnel qualifications and classification material. In some instances, however, where the States are attempting to "even off" differentials in personnel qualifications and compensation, there is danger of lowering personnel standards that have already been established in the child-welfare field. Because of this, it seems important for the Children's Bureau to make some statement as to recommended standards for children's workers. In view of the progress in interpreting the need for qualified personnel and also in view of the differentials which have existed between States, it seems more desirable for the Children's Bureau to adopt recommended personnel standards than for it to issue required minimum qualifications. The material on personnel already employed gives a basis for the development of recommended standards. The Child Welfare Division has prepared material which has been submitted to a subcommittee on personnel of the Advisory Committee on Community Child Welfare Services for consideration.

SALARIES, TRAINING, AND EXPERIENCE OF WORKERS PAID FROM FEDERAL FUNDS[2]

On October 1, 1939, the salaries of 652 workers employed in State programs of child-welfare services were paid in whole or in part from Federal funds.[3] Of these workers 258 were on the staffs of State welfare departments, and 394 were case workers in counties or other local areas.

Of the 258 workers on the staffs of State departments, 19 combined supervision of child-welfare work with supervision of various forms of public assistance; 70 of the 394 local workers had "coordinated" case loads, the most common combination being child-welfare services and aid to dependent children.

Salaries.

Of the workers on State staffs nearly one-fourth received annual salaries of $2,500 or more. The salaries of more than three-fifths of the local workers were from $1,500 to $2,000.

Annual salary	Number of workers	
	State	Local
Total	258	394
$2,500 or more	59	4
$2,000, less than $2,500	90	35
$1,500, less than $2,000	92	240
Less than $1,500	17	115

Education.

Graduation from college was reported for 91 percent both of the State and of the local workers.

Education	Number of workers	
	State	Local
Total	258	394
College graduate	226	329
Some college work	19	29
High school or equivalent	2	3
Not reported	11	33

Training in Schools of Social Work.

So far as could be ascertained, 59 percent of the State workers had received a year or more of training in a school of social work (not all in accredited schools) and 23 percent, less than a year. Of the local workers for whom this information was reported, 39 percent had attended schools of social work for a year or more and 32 percent, for less than a year.

Attendance at schools of social work	Number of workers	
	State	Local
Total	258	394
1 year or more	147	144
Less than 1 year	57	118
None	46	104
Not reported	8	28

At least 35 State workers and 63 local workers employed on October 1, 1939, attended schools of social work, mainly on educational leave, subsequent to their employment as child-welfare-service workers. In some States a considerable number of workers had received training in "in-service training centers."

Social-Service Experience.

Information in regard to work history prior to employment as child-welfare-service workers was insufficient for detailed analysis. "Child-welfare work" ranged from many years of casework and supervisory experience in agencies of high standing to comparatively short periods of somewhat general social-service work in the child-welfare field. "Family welfare," likewise, included emergency relief work as well as case work or supervisory work in private family-service agencies. In neither group was experience totaling less than 6 months included, and field work as a part of training in schools of social work was not counted as experience. "Other social work" included occupations such as hospital social service, supervision of recreation, various types of group work, and similar services. A number of workers were employed on State staffs for professional work in fields allied to social service—as psychiatrists, psychologists, and so forth. These, as well as State and local workers who had had no social-service experience but had been teachers, lawyers, ministers, nurses, and so forth, were classified as having "other professional experience."

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[2] Prepared by Emma O. Lundberg, Assistant Director, Child Welfare Division.

[3] These numbers do not include 20 persons who were on educational leave while attending schools of social work and 14 others paid from Federal funds who were receiving training in child-welfare agencies or were doing "field work" under supervision of State welfare workers and attending a school of social work. They also exclude the heads of 2 State child-welfare bureaus, whose salaries were paid in part from Federal funds, and 5 field workers in 2 States, whose salaries were paid from Federal child-welfare-service funds in lieu of payment of part of the salaries of 26 workers who supervised all forms of assistance, as well as child-welfare work, for the State welfare departments.

Following is the previous experience of State and local workers paid in full or in part from Federal child-welfare-service funds:

Social-service experience	*Number of workers*	
	State	*Local*
Total	258	394
Child welfare only	24	31
Child welfare and family welfare	67	41
Child welfare and other social work	12	7
Family welfare only	82	167
Family welfare and other social work	16	19
Other social work only	24	15
Other professional only	13	10
None	13	67
Not reported	7	37

BOOK NOTES

Association for Childhood Education publications Bulletins issued by the Association for Childhood Education (1201 Sixteenth Street NW., Washington, D. C.) during the past few months and priced at 35 cents each include:

School Housing Needs of Young Children (compiled by Jean Betzner, 1939; 40 pp.), in which the emphasis is placed on details of classroom interiors and on out-of-door facilities for work and play.

Growth Through School Living (compiled by Claire T. Zyve, 1940; 40 pp.), which contains selections dealing with the evaluation of the educational growth of children.

Exploring Your Community (compiled by Gladys L. Potter, 1940; 31 pp.), which contains selections showing how children have learned to use the community through experiences in the grocery store, the harbor, the power plant, trains, and so forth.

Other recent publications of the Association for Childhood Education include:

Uses for Waste Materials (compiled by the Committee on Equipment and Supplies, 1939; 12 pp.; 20 cents).

Equipment and Supplies for Nursery Schools, Kindergartens, Primary Schools (compiled by Committee on Equipment and Supplies; revised, January 1940; 39 pp.; 50 cents; in lots of 25 or more, 40 cents).

Yearbook of the Association for Childhood Education, 1939 (68 pp.; 25 cents).

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CLINICAL ORGANIZATION FOR CHILD GUIDANCE WITHIN THE SCHOOLS, by Elise H. Martens. U. S. Department of the Interior, Office of Education. Bulletin 1939, No. 15. 78 pp.

Prepared at the request of a conference of specialists who met in Washington in May 1938 at the invitation of the Commissioner of Education, this bulletin outlines the objectives of the conference as follows:

1. To analyze the problems of organization in school systems for the diagnosis and treatment of behavior problems.
2. To assist school authorities to develop effective service in this field.
3. To determine the spheres in which the Office of Education can be of service to school systems in the development of such programs.
4. To assist in planning a study by the Office of Education of clinical organization in school systems.

The growth of the clinical point of view in education is described. This started with the recognition of the value of a constructive pupil-teacher relationship and developed through the use of mental tests as a means to understanding individual differences and through the acceptance of the concept of the "whole child" as the object of attention.

Two functions of clinical service are emphasized: (1) The treatment of individual children; and (2) a preventive program that points out to school and community basic needs for the mental health of all children.

Most of the bulletin is devoted to describing various child-guidance organizations functioning in relation to schools. Representative organizations on a State-wide and county-wide basis are considered, and the manner is indicated in which school systems in small communities have provided child-guidance service by using State and county resources to supplement their needs. A discussion follows of programs in cities of moderate size and in large cities.

The final chapter presents the answers of the conference to questions pertinent to the establishment of child-guidance facilities in schools and communities, both large and small.

CHILD WELFARE IN GERMANY BEFORE AND AFTER NAZIISM, by Walter Friedlander and Earl Dewey Myers. University of Chicago Press, Chicago, 1940. 273 pp. $1.50. Processed.

Begun by the late Dr. Myers, of the faculty of the School of Social Work, Tulane University, this book was completed by Dr. Friedlander, formerly judge of juvenile and criminal court of Potsdam, Germany, and executive director of the Bureau of Public Assistance and Child Welfare of Berlin from 1921 to 1933. Dr. Friedlander came to the United States in 1937.

The authors trace the history of child welfare in Germany from its beginning until the present time; but most of their attention is concentrated on the post-war reconstruction period, 1919–32, with its emphasis on the child's health, happiness, and freedom of development.

The work of this period was based mainly on the National Child Welfare Law of 1922, which was welcomed by social workers in Germany and elsewhere as the culmination of Germany's effort to repair the damages done by the war to its young generation. "Every German child has the right to education for the development of physical, mental, spiritual, and social competence," is the opening sentence of the law, which introduced in Germany a centralized, nation-wide system of public child-welfare administration based on uniformity of method and procedure and on cooperation with private effort.

The authors describe child-welfare services under this law and other laws of the reconstruction period, treating in detail the care of dependent children and of those of illegitimate birth, correctional education, juvenile delinquency, child labor, unemployment, and other problems. They bring out the characteristics of the welfare work of the reconstruction period, often called the Weimar period: Concern for the individual child and the individual family; recognition of the child's rights to the best possible development and training; and emphasis on prevention of neglect and ill health, and on the need for trained social-service personnel.

The National Socialist Government, on coming into power early in 1933, announced its opposition to the Weimar system of public-welfare work. The emphasis in social work was shifted from individual welfare to the good of the National Socialist State and from Government support to private aid; and trained social workers were replaced by unpaid and mostly untrained volunteer members of the controlling party. These and other changes are described by the authors in several places in the book and in the concluding chapter.

An extensive bibliography and an index complete the report.

A MODERN PHYSICAL EDUCATION PROGRAM FOR BOYS AND GIRLS, by Vaughn S. Blanchard and Laurentine B. Collins. A. S. Barnes & Co., New York, 1940. 350 pp. $2.

The authors present this book as a practical guide in curriculum planning and in the everyday teaching of physical education. Its suggestions are based on the premise that the physical-education program in secondary schools should emphasize the cooperative and coeducational relationships of boys and girls as well as their needs as individuals.

Information is given on the organization of program material and on the contributions of the school administration and of the physical-education department to the curriculum. The general objectives, organization, and administration of the gymnasium, pool, and playground programs are described, and a brief chapter deals with the health program. The text is illustrated by many photographs and diagrams.

A section on supplementary materials deals with diagrams, plans, grading devices, procedures, and forms to facilitate the conduct of an activity program in physical education; regulations for swimming pools and duties of bath attendants; decathlon scoring systems; fieldball rules. Seventeen pages of selected references are given.

• BIRTH •

• GROWTH •

• CHILD HEALTH •

Summary of Report on Maternal and Child-Health Services Under Title V, Part 1, of the Social Security Act[1]

By Edwin F. Daily, M. D.

Director, Maternal and Child Health Division, U. S. Children's Bureau

Progress Report, 1939

Progress reports from the State health departments for the fiscal year ended June 30, 1939, show that many new activities have been undertaken by State and local health authorities and that many more children and pregnant women are benefiting from the funds granted to States under title V, part 1, of the Social Security Act.

Prenatal clinics and child-health conferences.—State health departments reported to the Children's Bureau that 347 new maternity clinic centers for prenatal and postpartum services were established during the fiscal year 1939, making a total of 1,229 such centers in 37 States[2] administered or supervised by State health departments (table 1). More than one-half of these 1,229 prenatal clinics have been established during the past 2 years. This count was limited to clinics conducted at least once a month with a physician in attendance. Seventeen percent of the rural counties and 26 percent of the urban counties were reported to have such prenatal clinics (table 2) under the supervision of the State health department.

Fourteen States reported no prenatal clinics under State health department auspices. Likewise, 2,500 counties reported no prenatal clinic under such auspices. It is of course recognized that within these 2,500 counties there are some cities in which prenatal clinics are conducted in hospitals, out-patient clinics, or by other agencies under public or private auspices. It is not known, however, how many such municipal clinics there are nor to what extent there is a need for additional clinic service. The Children's Bureau is planning a questionnaire survey to determine the number of communities that have a prenatal clinic at the hospital or in the community, where pregnant women who cannot afford to secure prenatal care in the office of practicing physicians may go for medical advice.

Five hundred and twenty-two new permanent child-health-conference centers were established during the year by State health departments, making a total of 2,394 centers in 41 States where conferences were conducted by physicians at least once a month (table 1). There are many more areas where these conferences are held only in the summer months or only during the school year or at irregular intervals when the doctors and nurses can arrange for them.

Ten State health departments report no child-health conferences conducted under State health department supervision. About 2,300 counties have no child-health conferences under the supervision of the State health agency. Some of these have child-health conferences conducted in cities under municipal or private auspices, but it is not known how many municipal centers there are, nor to what extent there is need for additional conferences in cities. A survey of municipal child-health conferences is needed.

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[1] Given before General Advisory Committee on Maternal and Child-Welfare Services, March 4, 1940.

[2] "State," as used in this report, includes the Territories of Alaska and Hawaii and the District of Columbia.

Table 1.—*Maternity and child-health-conference centers supervised by State health agencies, by State, year ended June 30, 1939*

State	Maternity centers (prenatal and postpartum)		Child-health-conference centers (infant and preschool)	
	Total, June 30, 1939	Number established during year ended June 30, 1939	Total, June 30, 1939	Number established during year ended June 30, 1939
United States	1, 229	347	2, 394	522
Alabama	55	35	14	------
Alaska	1	1	2	1
Arizona	27	5	37	13
Arkansas	7	4	6	2
California	6	1	299	32
Colorado	7	4	7	5
Connecticut	------	------	58	1
Delaware	1	------	20	------
District of Columbia	8	1	14	1
Florida	43	17	30	8
Georgia	181	88	204	80
Hawaii	30	3	89	8
Idaho	4	2	9	8
Illinois	------	------	------	------
Indiana	5	1	8	1
Iowa	------	------	------	------
Kansas	1	------	4	------
Kentucky	94	12	225	60
Louisiana	9	5	1	1
Maine	------	------	2	------
Maryland	51	11	64	4
Massachusetts	------	------	------	------
Michigan	------	------	------	------
Minnesota	17	------	26	------
Mississippi	122	59	234	76
Missouri	1	------	41	40
Montana	------	------	10	8
Nebraska	------	------	------	------
Nevada	1	------	9	2
New Hampshire	3	------	7	7
New Jersey	2	------	95	1
New Mexico	28	6	41	7
New York	43	------	56	8
North Carolina	171	17	171	17
North Dakota	------	------	------	------
Ohio	------	------	------	------
Oklahoma	18	4	61	33
Oregon	7	5	16	9
Pennsylvania	14	------	180	1
Rhode Island	------	------	20	1
South Carolina	117	25	65	22
South Dakota	3	1	3	1
Tennessee	19	1	73	16
Texas	22	7	36	9
Utah	9	1	66	6
Vermont	------	------	11	2
Virginia	74	19	26	6
Washington	1	1	------	------
West Virginia	27	11	54	25
Wisconsin	------	------	------	------
Wyoming	------	------	------	------

In many counties, however, where great need exists, child-health conferences have not been developed, often because medical groups have not wished to have the health department provide health supervision for well children in groups, even though the parents of these children would not otherwise secure such service.

Many of the State health departments have adopted the policy of paying qualified local physicians to conduct the clinics and in these States the services are now being provided on a much more satisfactory basis.

Some State and local medical societies are still reported to be opposed to any type of medical supervision on a clinic or conference basis. In all fairness it should be stated, however, that in many States the medical societies are rendering great assistance to the official health agencies in the development of these health services.

The number of local practicing physicians paid from maternal and child-health funds for their services in prenatal clinics last year was 1,178, an increase of 413 physicians (54 percent) over 1938 figures, and the number of such physicians in child-health conferences was 2,634, an increase of 489 physicians (23 percent) (table 3).

Dental programs.—State health departments reported that dental-health-education programs were carried on by dentists or dental hygienists in 900 counties in 36 States and that corrective dental services were provided in 630 counties in 29 States (table 4). The number of practicing dentists who were paid from maternal and child-health funds for their services in clinics or conferences was 766. What the developments should be in the dental aspects of the public-health program is not yet clear. Large sums have been spent on dental-health education, but few efforts have been made to determine, if it is possible to do so, whether or not dental health has been improved. Early correction of dental defects or diseases is of course desirable, but the problem is of such magnitude for the country as a whole that it cannot be met with the present resources of knowledge or professional personnel.

TABLE 2.—*Services provided under State health agencies in rural and urban counties,*[1] *year ended June 30, 1939*

Services provided	Total counties		Rural counties		Urban counties									
					Total		Size of largest city							
							10,000, less than 25,000		25,000, less than 50,000		50,000, less than 100,000		100,000 or more	
	Number	Percent of total counties	Number	Percent of rural counties	Number	Percent of urban counties	Number	Percent of counties with cities of this size	Number	Percent of counties with cities of this size	Number	Percent of counties with cities of this size	Number	Percent of counties with cities of this size
Total counties	[2] 3,076	-----	2,453	-----	623	-----	341	-----	121	-----	67	-----	94	-----
Counties with one or more specified services provided	2,187	*71*	1,671	*68*	516	*83*	280	*82*	102	*84*	56	*84*	78	*83*
Full-time health units	1,318	*43*	967	*39*	351	*56*	191	*56*	71	*59*	36	*54*	53	*56*
Maternity service:														
Prenatal and postpartum clinics	573	*19*	414	*17*	159	*26*	79	*23*	29	*24*	23	*34*	28	*30*
Prenatal and postpartum nursing service through:														
Home visits	1,918	*62*	1,481	*60*	437	*70*	232	*68*	86	*71*	53	*79*	66	*70*
Group instruction in maternity care	849	*28*	639	*26*	210	*34*	115	*34*	38	*31*	26	*39*	31	*33*
Organized home-delivery-nursing service	102	*3*	54	*2*	48	*8*	25	*7*	7	*6*	4	*6*	12	*13*
Infant and preschool:														
Medical conferences	753	*24*	511	*21*	242	*39*	115	*34*	50	*41*	36	*54*	41	*44*
Nursing service through:														
Home visits	1,957	*64*	1,501	*61*	456	*73*	241	*71*	93	*77*	53	*79*	69	*73*
Group instruction in child care	834	*27*	617	*25*	217	*35*	113	*33*	45	*37*	25	*37*	34	*36*
School:														
Medical examinations	1,252	*41*	942	*38*	310	*50*	170	*50*	55	*45*	34	*51*	51	*54*
Nursing supervision	1,819	*59*	1,399	*57*	420	*67*	221	*65*	89	*74*	48	*72*	62	*66*
Services of dentists or dental hygienists:														
Educational	900	*29*	659	*27*	241	*39*	122	*36*	49	*40*	27	*40*	43	*46*
Inspection	922	*30*	697	*28*	225	*36*	122	*36*	41	*34*	21	*31*	41	*44*
Corrective	630	*20*	472	*19*	158	*25*	78	*23*	28	*23*	19	*28*	33	*35*
Services of nutritionists	489	*16*	317	*13*	172	*28*	82	*24*	32	*26*	21	*31*	37	*39*
Counties with no specified services provided	889	*29*	782	*32*	107	*17*	61	*18*	19	*16*	11	*16*	16	*17*

[1] Counties classified as rural are those with no city of 10,000 or more population; all others are classified as urban.
[2] Includes New York City (5 counties), District of Columbia (1 county), Yellowstone Park (1 county), and Hawaii (4 counties).

Public-health nursing.—Approximately 2,000 of the 3,076 counties in the United States now have public-health nurses supervised by the health departments, who include maternity service in their nursing program (table 2). However, in far too many of these 2,000 counties only one public-health nurse is attempting to serve thousands of persons for all types of public-health-nursing services. More than 1,100 counties have no public-health nurses under State health departments who include service to maternity patients in their homes. There are now 6,080 public-health nurses rendering services under the maternal and child-health programs. Four hundred and eighteen of these nurses are supervisors or consultants; 5,662 are staff nurses (table 5).

There are 102 counties in the United States where nursing service at home during labor and at time of delivery is guaranteed by the health departments at all times, day or night. We believe that the presence of a trained nurse with the physician during this critical time is one of the most valuable nursing services provided under the public-health programs. At no time is the mother more in need of expert care. Nursing care of the infant during the first few hours of life will do more to reduce the number of infant deaths than nursing assistance at any other time during infancy. It is an expensive type of nursing service, requiring considerable time and, of course, special training in home-delivery-nursing technique. Therefore, this type of service can be developed in only a few areas each year. The patients like the service so much that they come from outside the county to be delivered at the homes of relatives or friends so that they may have the nurse's assistance. The doctors in every county where this service has been established have been the greatest "boosters" for this service. The Children's Bureau received a letter from a county medical society recently pleading for more funds to extend this service in that county. The State health officers cannot begin to meet the demand for this type of nursing service.

TABLE 3.—*Services for which practicing physicians, dentists, and nurses received payments, year ended June 30, 1939*

Type of service	Persons receiving payment					
	Physicians		Dentists		Nurses	
	Number	Number of States in which service was given	Number	Number of States in which service was given	Number	Number of States in which service was given
Prenatal and postpartum clinics	1, 178	24	22	4	----	-----
Infant and preschool conferences	2, 634	33	291	16	----	-----
Examinations of school children	634	9	453	11	----	-----
Clinic consultations	113	5	----	-----	----	-----
Home-delivery nursing	-----	-----	----	-----	322	9

Postgraduate education.—Almost 800 professional employees of health departments who render services in the maternal and child-health programs were given postgraduate education last year in recognized training centers, mostly schools of public health or of public-health nursing (table 6). One hundred and fifteen of these were physicians, 34 were dentists, 5 were nutritionists, and 640 were public-health nurses. The number of fully qualified professional personnel serving in these programs is still far below the demand. The States will have to continue for several years at least to provide special graduate training for some of their staff, if they expect to maintain high standards of qualifications. Whether or not the State health departments should continue to pay for graduate education for their staffs is a problem requiring further consideration. When public agencies cannot secure qualified personnel, should they assume the financial responsibility of training personnel? Postgraduate education for practicing physicians and dentists provided in 1939 included—

2,152 obstetric lectures and teaching clinics in 617 communities, with more than 14,000 physicians attending.

1,284 pediatric lectures in 499 communities, with more than 14,000 physicians attending.

282 lectures on children's dentistry in 158 communities, with about 5,000 dentists attending.

Many State health departments now plan postgraduate-education programs on a permanent basis, making them easily available to all physicians in the State, and are adding courses on the treatment of syphilis and pneumonia, and other branches of medicine. The Children's Bureau has constantly urged the State health departments to develop these courses in cooperation with State medical schools whenever possible. The most interesting development in postgraduate education planned by State health departments under these programs is the short clinical postgraduate course (of 2 to 5 weeks' duration) being made available in cooperation with the larger medical schools. The lecture courses and clinics in communities throughout the State showed that many practicing physicians wished to go to the larger teaching centers for short clinical courses. There were few places in the United States where such courses were offered. This year at least eight State health departments have made these courses possible in cooperation with medical schools. The Federal grants-in-aid are paying the entire cost in practically every instance. These are small beginnings of what may prove to be a new pattern of financing graduate medical education.

TABLE 4.—*Number of counties with specified type of service, by State, year ended June 30, 1939*

State	Total counties with 1 or more services	Full-time health units	Maternity service				Infant and preschool health			School health		Services of dentists or dental hygienists			Services of nutritionists	No specified service provided
			Prenatal or postpartum clinics	Prenatal or postpartum nursing service through—		Organized home-delivery nursing service	Medical conferences	Nursing service through—		Medical examinations	Nursing supervision	Educational	Inspection	Corrective		
				Home visits	Group instruction in maternity care			Home visits	Group instruction							
United States	2,187	1,318	573	1,918	849	102	753	1,957	834	1,252	1,819	900	922	630	489	889
Alabama	67	67	27	67	22	1	4	66	2	67	67	18	18	19	35	----
Alaska [1]	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----
Arizona	10	6	9	10	5	----	10	10	2	5	8	----	5	7	----	4
Arkansas	75	68	7	75	26	----	6	75	24	41	74	15	6	15	----	----
California	49	18	6	21	2	1	39	42	1	----	48	32	31	17	5	9
Colorado	36	2	5	36	36	5	5	36	36	2	36	----	----	----	----	27
Connecticut	8	----	----	1	2	1	8	8	----	----	----	8	8	----	8	----
Delaware	3	3	1	3	1	----	3	3	1	3	3	3	3	----	3	----
District of Columbia	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	----
Florida	17	17	15	17	16	1	12	17	15	17	17	14	13	13	----	50
Georgia	159	54	84	159	91	1	64	158	66	53	159	71	99	99	3	----
Hawaii	4	----	4	4	4	----	4	4	4	4	4	----	----	----	----	----
Idaho	11	9	3	9	9	4	3	9	10	11	10	----	----	----	3	33
Illinois	90	69	----	37	16	5	----	39	16	42	85	----	----	----	34	12
Indiana	71	23	5	59	55	3	13	63	60	58	63	43	10	7	6	21
Iowa	27	27	1	27	15	1	----	27	15	2	26	----	2	----	----	72
Kansas	79	4	2	26	26	2	1	24	24	15	25	25	72	21	42	26
Kentucky	92	88	82	88	4	11	86	88	5	87	87	41	38	43	----	28
Louisiana	41	41	7	41	22	2	1	41	17	41	38	41	41	41	21	23
Maine	16	16	----	16	1	1	1	16	----	----	11	16	1	----	16	----
Maryland	23	23	20	23	13	3	13	23	13	23	23	----	12	12	18	----
Massachusetts	14	3	----	2	7	2	10	8	3	1	4	14	----	----	14	----
Michigan	69	60	----	60	2	2	----	60	1	60	60	----	51	52	35	14
Minnesota	59	16	1	44	42	6	10	53	51	29	55	32	28	12	19	28
Mississippi	56	39	39	51	51	1	39	51	51	39	51	27	27	----	----	26
Missouri	112	112	1	112	1	----	7	112	1	61	61	76	63	50	----	2
Montana	35	4	----	30	1	1	6	32	7	5	34	5	4	2	----	21
Nebraska	16	16	----	16	4	----	----	16	----	16	16	16	----	----	----	77
Nevada	17	----	1	17	12	----	3	17	17	13	17	10	10	10	----	----
New Hampshire	10	2	2	10	10	2	5	10	9	----	----	----	7	7	----	----
New Jersey	21	21	2	19	4	20	17	19	12	19	19	12	12	12	21	----
New Mexico	31	31	12	31	10	----	17	31	8	28	31	----	1	1	----	----
New York	57	57	26	57	9	4	19	57	20	----	55	13	13	5	54	5
North Carolina	77	74	50	55	50	1	50	55	50	55	55	67	67	67	11	23
North Dakota	26	6	----	26	8	3	----	26	1	----	26	----	----	----	----	27
Ohio	86	49	----	73	9	3	----	75	9	81	78	37	42	7	2	2
Oklahoma	77	13	6	77	6	1	37	77	5	37	38	42	34	17	76	----
Oregon	35	15	8	34	13	1	9	34	11	21	34	18	23	5	1	1
Pennsylvania	66	----	11	66	1	----	59	66	1	66	66	9	9	----	1	1
Rhode Island	5	5	----	5	2	----	5	5	2	3	5	----	1	----	----	----
South Carolina	46	46	46	45	39	1	36	45	39	43	40	23	20	----	----	----
South Dakota	37	11	3	37	31	3	4	37	31	28	37	19	19	----	----	32
Tennessee	57	57	10	57	17	2	26	55	20	55	55	20	42	36	----	38
Texas	44	18	13	44	31	----	18	44	30	20	42	15	27	16	4	210
Utah	29	29	4	27	1	2	24	25	1	29	28	19	20	5	22	----
Vermont	11	11	----	11	11	3	11	11	11	11	11	11	11	----	----	3
Virginia	57	38	37	37	37	----	35	35	35	----	----	31	31	31	----	43
Washington	39	17	1	39	6	----	----	39	----	----	----	4	----	----	----	----
West Virginia	39	29	21	39	32	1	31	37	30	31	36	----	----	----	----	16
Wisconsin	71	3	----	68	35	----	----	67	65	29	71	52	----	----	34	----
Wyoming	9	----	----	9	----	----	1	8	1	----	9	----	----	----	----	15

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[1] Alaska has no county system.

TABLE 5.—*Specified types of activities, by State, year ended June 30, 1939*

State	School health education				Number of communities having medical examinations of school children	Instruction in nutrition		Number of nutritionists giving nutrition service		Number of public-health nurses rendering MCH services under administration or supervision of State health agency		
	In teacher-training schools	In public schools	In classes in high schools in maternal and infant care			In-service education for physicians, dentists, dental hygienists, and nurses	Cooperation with other agencies	Under administration or supervision of State health agency	Consultation service to MCH program	Total	Supervisory or advisory	Nonsupervisory
			Number of communities	Total enrollment								
United States	(1)	(1)	1,043	66,245	8,118	(1)	(1)	42	99	6,080	418	5,662
Alabama	Yes	Yes	------	--------	(2)	Yes	Yes	2	------	174	16	158
Alaska	No	Yes	------	--------	26	No	No	------	1	13	1	12
Arizona	Yes	Yes	1	20	(2)	Yes	Yes	------	------	33	2	31
Arkansas	Yes	Yes	12	160	(2)	No	No	------	------	104	6	98
California	No	Yes	------	--------	------	Yes	Yes	3	1	117	13	104
Colorado	Yes	Yes	3	30	3	Yes	Yes	------	------	62	8	54
Connecticut	Yes	Yes	------	--------	------	Yes	Yes	1	------	11	1	10
Delaware	Yes	Yes	5	125	51	Yes	Yes	1	1	26	3	23
District of Columbia	No	No	------	--------	------	No	Yes	1	------	73	9	64
Florida	No	Yes	------	--------	(2)	No	Yes	------	------	62	16	46
Georgia	Yes	Yes	(2)	(2)	(2)	Yes	Yes	------	1	188	5	183
Hawaii	No	Yes	------	--------	(2)	Yes	Yes	------	------	65	13	52
Idaho	Yes	Yes	5	(2)	71	Yes	Yes	------	5	30	5	25
Illinois	Yes	Yes	------	--------	189	Yes	Yes	3	------	69	13	56
Indiana	Yes	Yes	10	1,200	6	Yes	Yes	1	5	508	15	493
Iowa	Yes	Yes	67	1,134	2	No	Yes	------	------	45	5	40
Kansas	Yes	Yes	------	--------	(2)	Yes	Yes	1	------	46	4	42
Kentucky	Yes	Yes	(2)	(2)	880	Yes	Yes	------	(2)	155	5	150
Louisiana	Yes	Yes	(2)	(2)	(2)	Yes	Yes	1	------	107	8	99
Maine	No	Yes	------	--------	------	Yes	Yes	1	------	32	4	28
Maryland	No	Yes	------	--------	(2)	Yes	Yes	1	1	94	2	92
Massachusetts	Yes	Yes	------	--------	1	Yes	Yes	8	21	(2)	(2)	(2)
Michigan	Yes	Yes	129	36,774	60	Yes	Yes	1	2	370	22	348
Minnesota	Yes	Yes	83	2,033	52	Yes	Yes	1	3	166	8	158
Mississippi	Yes	Yes	235	11,854	630	Yes	Yes	------	------	125	8	117
Missouri	Yes	Yes	------	--------	1,308	Yes	Yes	------	2	107	5	102
Montana	No	Yes	------	--------	------	Yes	No	------	1	55	3	52
Nebraska	No	Yes	------	--------	248	No	Yes	------	------	20	5	15
Nevada	No	Yes	6	221	43	Yes	Yes	------	4	12	1	11
New Hampshire	Yes	No	1	100	------	Yes	Yes	1	2	25	------	25
New Jersey	No	Yes	9	250	535	Yes	No	------	19	218	18	200
New Mexico	Yes	Yes	(2)	(2)	(2)	Yes	Yes	------	------	62	6	56
New York	No	No	------	--------	------	Yes	Yes	3	8	556	39	517
North Carolina	Yes	Yes	------	--------	76	Yes	Yes	1	(2)	265	26	239
North Dakota	Yes	Yes	------	--------	------	Yes	Yes	------	------	45	3	42
Ohio	No	Yes	------	--------	94	Yes	Yes	3	------	618	24	594
Oklahoma	Yes	Yes	5	162	271	Yes	Yes	1	2	92	12	80
Oregon	Yes	Yes	------	--------	(2)	No	No	------	------	87	8	79
Pennsylvania	No	No	------	--------	1,414	No	Yes	3	------	167	9	158
Rhode Island	No	Yes	------	--------	6	Yes	Yes	------	1	19	2	17
South Carolina	No	Yes	9	905	1,228	No	No	------	9	95	6	89
South Dakota	No	Yes	62	761	98	Yes	Yes	------	1	44	3	41
Tennessee	Yes	Yes	80	2,262	(2)	Yes	Yes	------	------	165	5	160
Texas	Yes	Yes	5	200	750	Yes	No	1	------	150	21	129
Utah	Yes	Yes	------	--------	------	Yes	Yes	1	------	57	7	50
Vermont	Yes	Yes	------	--------	48	Yes	Yes	------	------	19	2	17
Virgina	Yes	Yes	(2)	(2)	(2)	Yes	Yes	------	------	86	5	81
Washington	Yes	Yes	------	--------	------	Yes	Yes	1	2	90	3	87
West Virginia	Yes	Yes	(2)	(2)	(2)	Yes	Yes	------	------	65	5	60
Wisconsin	Yes	Yes	316	8,054	28	Yes	Yes	1	7	273	6	267
Wyoming	No	Yes	------	--------	------	Yes	Yes	------	------	13	2	11

[1] School health education was reported in teacher-training schools by 33 States and in public schools by 47; instruction in nutrition was reported through in-service education by 42 States and through cooperation with other agencies by 44.

[2] Not reported.

It has been recommended that physicians and nurses participating in prenatal clinics and child-health conferences under maternal and child-health programs be given special training for this type of service and that continued supervision and consultation be made available. Several States have now developed practical courses in prenatal care and the health supervision of well children for the physicians employed to conduct clinics and conferences. Other States are sending these physicians to special courses in nearby States. Eighty-three full-time pediatricians and obstetricians have been employed on State staffs to work with local physicians conducting clinics and conferences, advising them and observing whether or not a satisfactory type of service is being rendered. The American Academy of Pediatrics has taken an active interest and plans to have its members assist the State health agencies in systematically evaluating the services rendered in the child-health conferences.

TABLE 6.—*Postgraduate education received by staff members, year ended June 30, 1939*

Type of course and staff members receiving—	Number of States in which given	Number of staff members receiving
All types of courses	44	794
Physicians	21	115
Dentists	9	34
Nutritionists	5	5
Public-health nurses	42	[1] 640
Supervisory	29	75
Nonsupervisory	40	565
General public-health courses	39	554
Physicians	17	94
Dentists	6	6
Nutritionists	2	2
Public-health nurses	38	[1] 452
Supervisory	19	31
Nonsupervisory	36	421
Other types of courses	27	246
Physicians	10	21
Obstetrics	3	3
Pediatrics	3	7
Venereal disease	3	10
Type not reported	1	1
Dentists:		
Public-health dentistry	3	28
Nutritionists:		
Nutrition	3	3
Public-health nurses	24	[1] 194
Maternity nursing care	11	103
Pediatrics	3	4
Orthopedic nursing	2	25
Venereal disease	5	27
Physiotherapy	1	2
Public-health-nursing supervision	1	6
Type not reported	5	27

[1] Of these 640 nurses, 6 received both general public-health and other types of training.

Standards for maternity hospitals and homes.—The Children's Bureau has given to the States a list of important suggestions that should be considered in any new legislation formulating standards for hospitals and homes accepting maternity patients and has urged the employment of qualified staff by the health departments to carry out the provisions of these laws. Five States have recently adopted rules and regulations for the conduct of hospitals and homes accepting maternity patients, and several States have strengthened the existing rules and regulations on this subject. The health departments of 17 States and Hawaii now have the responsibility of licensing and regulating hospitals or homes accepting maternity patients.

Merit system.—Within the past few months 33 health departments have been working toward the establishment of a merit system of personnel administration which, among other things, requires the selection of personnel on the basis of qualifications only. The remaining 19 State health departments already were operating under civil-service laws. Rules and regulations governing the merit system and the classification and compensation plans have been submitted or are being prepared by the State agencies.

Syphilis control.—Twenty States now have laws requiring blood tests for syphilis before marriage certificates will be issued. Eighteen States now have laws requiring physicians to take a blood test for syphilis on all pregnant patients. In New York State, where such a law is in force, a study has shown that 95 percent of the pregnant women received blood tests for syphilis, but only one-fourth of the tests were made before the fifth month of pregnancy, and one-third of the tests were taken at or near time of delivery. The Children's

Bureau would be interested to learn what the reaction has been to these laws in the States. They are considered a great step forward. There is need, however, for careful analyses and follow-up studies.

PROPOSED EXPENDITURES FOR THE SERVICES OF PROFESSIONAL PERSONNEL, 1940

The following is a summary of amounts budgeted for the fiscal year 1940 for various types of services rendered by professional personnel:

Professional personnel and services	*Amount paid*
418 physicians on State and local staffs	$1,051,459.50
Practicing physicians	336,292.84
68 dentists on State and local staffs	197,074.50
33 dental hygienists on State and local staffs	66,883.00
Practicing dentists and dental hygienists	152,898.31
2,760 public-health nurses on State and local staffs	3,920,528.64
Local graduate nurses	12,337.02
49 nutritionists on State and local staffs	139,260.00
40 health educators on State and local staffs	125,918.50
Postgraduate education—medical, dental, nursing	252,530.64

This summary does not include the proposed expenditure of the additional $1,000,000 appropriated by Congress for the first 6 months of 1940. The States have budgeted practically all of the new appropriation: the largest share has been used by the States for employing additional obstetricians and pediatricians to supervise and teach in the clinics and conferences, to increase the amounts available to pay for medical, dental, and nursing services in these clinics, for postgraduate education and, in selected areas, to pay for complete medical and hospital care at time of delivery and also for sick children.

PUERTO RICO

Puerto Rico now has an approved plan for maternal and child-health services. Puerto Rico has a population of about 2 million, a birth rate twice that of the United States, and excessively high maternal and infant mortality rates. More than 68,000 live births are reported each year, only 10 percent of which are attended by a doctor. The allotment of Federal maternal and child-health funds for Puerto Rico will be approximately $190,000 for the fiscal year 1941.

MATERNAL AND INFANT MORTALITY RATES

Results of widespread efforts to improve the health of maternity patients and children as shown by mortality rates are extremely gratifying.

The maternal mortality rate for 1938 was 11 percent lower than that for 1937 and 23 percent lower than that for 1936. Provisional rates indicate a 9 percent further decrease in 1939. The number of maternal deaths in 1938 was 9,953. This is 816 fewer than in 1937 and 2,229 fewer than in 1936.

The infant mortality rate for 1938 was 6 percent lower than that for 1937 and 11 percent lower than that for 1936. Provisional rates indicate a 6 percent further decrease in 1939. The number of infant deaths in 1938 was 116,702. This is 3,229 fewer deaths than in 1937 and 5,833 fewer than in 1936.

NEWS NOTES

American Committee on Maternal Welfare issues new periodical

The Mother, quarterly bulletin of the American Committee on Maternal Welfare (650 Rush Street, Chicago) made its first appearance in April 1940. *The Mother*, a subscription to which is included with membership on the committee, is to serve as a means of disseminating information among medical, nursing, public-health, educational, institutional, and other groups, regarding the plans and programs of maternal welfare which are being carried out in various communities. It is not intended to be a medical journal or to present scientific articles.

Volume 1, number 1 (April 1940), contains a report, Classification of the Toxemias of Pregnancy, which has been developed by the committee to overcome the lack of uniform terminology in this field.

American Public Health Association Year Book

The Tenth Annual Year Book, American Public Health Association, 1939–1940, contains the reports of section committees on engineering, food and nutrition, industrial hygiene, laboratory, public-health education, public-health nursing, and vital statistics; also the committee list, 1939–40, containing the names of the committee members and resolutions adopted by the association, October 17, 1939.

Supplement to American Journal of Public Health, Vol. 30, No. 2 (February 1940).

* * * * *

Bulletins of National Society for Crippled Children

As a monthly service to its affiliated societies and to its institutional members, the National Society for Crippled Children, Elyria, Ohio, has begun to issue a *Bulletin on Current Literature* of interest to workers with crippled children. Volume 1, number 6, appeared in June 1940.

Directory of Camps and Summer Activities for Crippled Children in the United States, issued by the International and National Societies for Crippled Children, Elyria, Ohio, under date of May 1940, as Institutional Bulletin No. 29, lists 59 agencies in 19 States and the District of Columbia that maintain camps or other special summer programs for crippled children. These include camps specializing in various types of crippling, such as post-infantile-paralysis cases and spastics. Most of them accept both private cases at moderate rates and free cases. Many provide also for normal children.

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CORRECTION

In "Methods of Teaching Prevention of Diarrhea in New Mexico," by Hester B. Curtis, M. D., in *The Child*, May–June 1940, page 295, column 2, lines 14–16 should read:

All the local public-health nurses visit mothers in their own homes.

BOOK NOTES

Directory of Medical Specialists Certified by American Boards, 1939. Paul Titus, M. D., directing editor. Published for the Advisory Board for Medical Specialties by Columbia University Press, New York, 1940. 1573 pp. $5.

The publication of an official directory, listing the names, addresses, and biographic data of the more than 14,000 specialists certified by the American Boards was authorized by the Advisory Board for Medical Specialties at its meeting in Chicago, February 1939.

The directory has been designed closely to coordinate the work of the several special boards by combining in one volume the details of the activities of all the boards, with lists of their diplomates.

The first section outlines the general aim of the Advisory Board for Medical Specialties toward improving the standards of graduate medical education and training and the practice of medical specialties in the United States and Canada. The Advisory Board is composed of representatives from each of the special American Boards and certain other groups directly concerned with graduate medical education.

Separate sections are devoted to the special boards. The last section contains an alphabetical list of diplomates with the address of each and the name of the special board granting his certification.

Manual of Public Health Nursing. Prepared by the National Organization for Public Health Nursing. Third edition. Macmillan Co., New York, 1939. 529 pp.

The range of subjects covered by the 1939 Manual of Public Health Nursing, prepared by the National Organization for Public Health Nursing, is similar to that in the 1932 edition. The 1939 edition, however, has been divided into three main sections instead of two. The first part, Administration and Organization, discusses the definition of public-health nursing, plan of work, administrative and office details, and relationships with other agencies. The second part, Family Health, deals with subjects such as family-health service, home visits, health classes, conferences, clubs and clinics, and standing orders. One hundred and fifty-five pages are used for these two sections. The third part, Services to the Family, is devoted to a detailed discussion of procedures and techniques of the various nursing services.

This long-awaited revision of the manual is designed to serve many of the needs of public-health nurses, particularly those of nurses who are working alone without close supervision. Although an increasing number of agencies, both private and official, have prepared and made available to their staffs manuals of procedure applicable to their immediate situations, organizations do not always have convenient access to reliable information in regard to the changing concepts and newer aspects of public-health nursing.

TEETH, HEALTH, AND APPEARANCE, by Lon W. Morrey, D. D. S. American Dental Association, 212 East Superior Street, Chicago, 1940. 47 pp.

Diagrams and photographs showing healthy and diseased teeth, and the development, structure, and position of teeth in the jaw are accompanied by brief textual explanations in large type. The correct method of brushing the teeth is shown. The material in this volume was developed by the supervisor of the Bureau of Public Relations of the American Dental Association.

The principal purpose of this book is to show how a clean, healthy condition of the teeth can be obtained without great expense, if the teeth are cared for in time. "Preventive dentistry includes more frequent cleaning of the teeth, the filling of small cavities, and the preservation of healthy deciduous teeth until they are normally shed. It also includes the correction of malocclusion in young children and the early recognition and treatment of infection of the gums."

MOTHERS' MILK. Mothers' Milk Bureau of the Children's Welfare Federation of New York City. New York, 1939. 20 pp.

Reprints of three articles on mothers' milk by Carl Laws, M. D., and Esther G. Skelley, R. N., which appeared in the August and September 1938 and April 1939 issues of the *American Journal of Nursing*, make up this pamphlet.

The Mothers' Milk Bureau, it is stated in the foreword, has collected and distributed more than 1,641,000 ounces of mothers' milk to approximately 7,050 babies during the past 18 years and presents this booklet in the hope that it will stimulate wider interest in the use of mothers' milk for feeding premature and ill infants.

One article gives a general account of the work of the Mothers' Milk Bureau; the second describes the preservation of maternal milk; and the third is on the technique of manual expression of mothers' milk.

THE HEALTH OF THE SCHOOL CHILD, by Max Seham, M. D. Reprinted from *American Teacher*, December 1939. 4 pp.

"The new school hygiene," states Dr. Seham, "demands the prevention, early recognition, and early treatment of all deviations from the normal that interfere with efficient school work whether they are physical handicaps or behavior inadequacies." He gives a brief summary of replies by city and county school superintendents in Minnesota to a questionnaire concerning the need for and supply of school-health services.

THE COMPLEAT PEDIATRICIAN; practical, diagnostic, therapeutic, and preventive pediatrics, by Wilburt C. Davison, M. D. Third edition. Duke University Press, Durham, N. C., 1940. 256 pages plus index. $3.75.

This third edition, in which 10,000 lines were changed, was written because of the accumulation of additional pediatric information during the past 3 years. The preface points out that, as few physicians have leisure to read the rising flood of pediatric literature, this book may prove useful, "not only as a placer miner's sieve to collect and sort the nuggets, but also to add them to the present hoard."

The author gives instructions for using the book, in which the symptoms and diseases have been divided into seven chapters on the basis of the anatomical system chiefly involved.

FIFTEEN YEARS' OBSERVATION OF CHILDREN WITH RHEUMATIC HEART DISEASE, by William D. Stroud, M. D., and Paul H. Twaddle, M. D. *Journal of American Medical Association*, Vol. 114, No. 8 (Feb. 24, 1940), pp. 629–634.

The cases of 685 children threatened with or suffering from rheumatic heart disease who were treated at the Children's Heart Hospital of Philadelphia between 1922 and 1937 are reported in this paper. A previous report, covering the period 1922 to 1932 appeared in the *Journal of the American Medical Association* for August 12, 1933.

Of the total group, 59.1 percent were able to go to school, were working, or were unemployed in 1937; 4.6 percent were unable to work or were in a hospital; 15.3 percent could not be located; and 21.0 percent had died. The greatest mortality occurred 3 to 5 years after the primary manifestation of rheumatic fever.

SOME ADMINISTRATIVE ASPECTS OF MATERNITY AND CHILD WELFARE IN INDIA, by Jean M. Orkney, Dr. P. H. *Mother & Child* (National Council for Maternity & Child Welfare, Aldwych House, Aldwych, London, W. C. 2), Vol. 10, No. 9 (December 1939), pp. 323–328.

The director of the Maternity and Child Welfare Bureau, Indian Red Cross Society, describes in this article the functioning of the bureau and the administrative history of maternity and child-welfare services in India.

Experimental rural health units have been established in four Provinces and in two native States. The Provincial units are under the general direction of the Provincial director of public health, assisted by "a full-time staff of one medical officer of health, one assistant medical officer (who is generally a woman), four sanitary inspectors, four health visitors, eight midwives, a clerk, and a sanitary squad of menials." These units serve a population of approximately 40,000, dwelling in 150 to 180 villages and having a birth rate of about 40 per 1,000 population.

Congressional Committees Dealing With Social and Economic Conditions of Migratory Workers

The La Follette Civil Liberties Committee, a subcommittee of the Senate Committee on Education and Labor, heard testimony from representatives of a number of Government departments, including the Department of Labor, in May 1940. The hearings were conducted in Washington with Senator La Follette or Senator Thomas presiding. These hearings grew out of the fact that, after hearing testimony in California regarding denial of civil liberties, especially to agricultural workers, the committee recognized the difficulties of this group are grounded primarily in the economic situation of migratory agricultural labor.

Testimony on the economic and social background of problems confronting migratory agricultural laborers was presented by the Secretary of Labor and by representatives of the Children's Bureau, the Women's Bureau, and the Division of Labor Standards of the United States Department of Labor.

The Children's Bureau statements on the implications of the general child-welfare problems of migratory workers (Katharine F. Lenroot), on the health services available to persons in rural communities, particularly migrants (Martha M. Eliot, M. D.), and on the extent and conditions of child labor in agriculture and the legal regulation of agricultural child labor (Beatrice McConnell) will be published in the report of testimony of these hearings.

A committee of the House of Representatives has been appointed in accordance with House Resolution 63, passed in April 1940, to inquire into interstate migration of destitute persons and to study their social and economic needs with a view to obtaining facts to aid the House of Representatives in enacting remedial legislation. Plans for hearings in different parts of the country are now under way.

New Jersey Adopts New Child-Labor and Compulsory-School-Attendance Laws

As a result of companion measures approved by the Governor of New Jersey on June 25, and effective September 1, 1940, New Jersey has materially strengthened its child-labor and compulsory-school-attendance standards. Heretofore children were permitted to leave school for work at 14 years; now school attendance is required to 16 years of age. Nonresident children under 16 are prohibited from working in New Jersey during periods when the law of the State of their residence would require them to be in school.

The basic minimum age for employment is raised from 14 to 16 years. New Jersey thus becomes the thirteenth State to adopt a 16-year minimum-age standard. No child under 16 may work in factories at any time or in any occupation during school hours. Children 14 and 15 years of age may work outside school hours and during vacation in nonfactory and nonprohibited employment. Work outside school hours in agriculture and in street trades is regulated. A minimum age of 12 years is set for farm work, and in street trades there is a minimum age of 18 for girls and 14 for boys (12 for newspaper carriers on residential routes). Farm work and domestic service performed outside school hours for the child's parent and in connection with his own home are entirely exempt from the new law.

Employment certificates are required for employment of minors up to 18 years of age for all work except in agriculture and street trades, special permits being required for children up to 16 years of age working on farms and in street trades. Provision is also made for issuance of age certificates for young persons 18 to 21 years of age.

Hours-of-work standards are strengthened. An 8-hour day, a 40-hour week, and a 6-day week are established, and night work is prohibited for minors under 18, with limited exemptions.

A minimum age of 18 years is set for work in specified hazardous occupations and in occupations found hazardous by the Commissioner of Labor.

N. J. Laws of 1940, chs. 153 and 154.

Issuance of Age Certificates Under Fair Labor Standards Act

Forty-four jurisdictions were redesignated, in a child-labor regulation issued June 26 by the Chief of the Children's Bureau, as States in which State age or employment certificates or permits shall have the same force and effect as Federal certificates of age under child-labor provisions of the Fair Labor Standards Act of 1938. The designation is effective for 1 year beginning July 1, 1940. The designated jurisdictions are:

Alabama
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Hawaii
Illinois
Indiana
Iowa
Kansas
Kentucky
Maine
Maryland
Massachusetts
Michigan
Minnesota
Missouri
Montana
Nebraska
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Dakota
Tennessee
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming

Alaska and Puerto Rico will be visited this summer with a view to making provision for issuing age certificates. Arrangements are also under way for making available certificates of age in Nevada and Louisiana. These States and Territories are now operating under a temporary regulation providing for the acceptance of birth or baptismal certificates as proof of age.

Federal certificates of age are being issued in Idaho, Mississippi, South Carolina, and Texas, with the close cooperation of State officials.

Employers in establishments producing goods for shipment in interstate commerce may protect themselves from unintentional violation of the child-labor provisions of the Fair Labor Standards Act by obtaining age certificates for minors 16 and 17 years of age in their employ and for minors 18 and 19 years of age employed in occupations which have been found and by order declared by the Chief of the Children's Bureau to be particularly hazardous for the employment of minors between 16 and 18 years of age or detrimental to their health or well-being. The occupations for which hazardous-occupations orders have been issued[1] are: (1) All occupations in or about plants manufacturing explosives or articles containing explosive components; and (2) the occupations of motor-vehicle driver or helper on such vehicles.

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[1] A proposed finding and order for the coal-mining industry is expected to become effective September 1, 1940.

BOOK NOTES

First annual report of Wage and Hour Division The First Annual Report of the Administrator of the Wage and Hour Division, United States Department of Labor, was submitted to Congress in January 1940. It was referred to the Committee on Education and Labor and is now available in printed form. The Administrator points out in the introduction that:

> The social and legislative history of the last 40 or 50 years illustrates a dwindling faith in the ability of a laissez faire economy alone to create permanent happiness and prosperity for every citizen, for countless measures have been taken by both State and National Governments to give direction to our economic life. . . . The Fair Labor Standards Act may be properly understood in its historical setting as representing one more effort to direct economic forces into socially beneficial channels.

The report covers the legislative history, the meaning, the economic coverage and effects, and the enforcement of the wage-and-hour provisions of the Fair Labor Standards Act. There are also chapters on the 10 industry committees set up during 1939, on administrative exemptions for learners, apprentices, handicapped workers, and messengers and exemptions in connection with defining area of production and determining industries of a seasonal nature. Chapters on administration and on legislative amendments are also included.

First Annual Report of the Administrator of the Wage and Hour Division, U. S. Department of Labor, for the Calendar Year 1939. U. S. Government Printing Office, Washington, 1940. 163 pp.

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Work Projects Administration studies of reemployment and industrial techniques During the past few months the Work Projects Administration has issued reports of the following studies in the series on reemployment opportunities and recent changes in industrial techniques being carried on by its National Research Project under the direction of David Weintraub:

Farm-City Migration and Industry's Labor Reserve, by Francis M. Vreeland and Edward J. Fitzgerald. Report No. L–7, Philadelphia, August 1939. 67 pp. Processed.

Labor and the Shut-Down of the Amoskeag Textile Mills, by Daniel Creamer and Charles W. Coulter. Report No. L–5, Philadelphia, November 1939. 342 pp. Processed.

Mechanization in the Lumber Industry; a study of technology in relation to resources and employment opportunity, by Alfred J. Van Tassel with the assistance of David W. Bluestone. Report No. M–5, Philadelphia, March 1940. 201 pp. Processed.

Trade-Union Policy and Technological Change, by Harry Ober. Report No. L–8, Philadelphia, April 1940. 129 pp. Processed.

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URBAN YOUTH: THEIR CHARACTERISTICS AND ECONOMIC PROBLEMS. Urban Surveys Section, Division of Research, Works Progress Administration, Washington, 1939. 52 pp. Mimeographed.

In this preliminary report of the Survey of Youth in the Labor Market are given some of the more important findings, pending a more complex statistical analysis of the material. It follows the "changing problems of youth as they attempt the metamorphosis from wards of society in the schools to wage earners and producers of wealth in shops, factories, and offices." For this purpose a sample of grade-school graduates, rather than high-school graduates, was chosen. More than 40,000 youth in 8 cities representing various sections of the country were interviewed in the fall of 1938. At the time of the interview they ranged from 19 to 23 years of age, and those who had gone to high school had had time to finish it and spend a year working or seeking work.

The work histories of these young persons show that some made the transition from school to industry with little difficulty. Others, however, after years of effort, were unemployed. Still others were engaged in temporary work, in dead-end jobs, or in work paying substandard wages. Many of the youth in these jobs were dissatisfied and were striving to obtain other work. These, as well as unemployed youth, constitute a problem in adjustment.

CHILDREN IN STRAWBERRIES, by Raymond G. Fuller. Publication No. 380, National Child Labor Committee, 419 Fourth Avenue, New York, March 1940. 22 pp. 25 cents.

The strawberry fields of Arkansas and Kentucky, where the 81 families included in this study were interviewed by Charles E. Gibbons of the National Child Labor Committee, are a part of the strawberry region of the Mississippi Valley to which many migrant families who were formerly tenant farmers in the cotton fields are turning.

Most of the children of the strawberry migrants, except for the youngest, worked in both the strawberry and the cotton fields. Of the 236 children under 16 years of age in the 81 families surveyed, 163 were regular workers, including 2 who were 5 years of age and 6 who were 6 years of age. All but 1 of the children 12 to 15 years of age worked regularly, for the same number of hours as did adult workers, and 35 percent of them had finished only the first or second school grade or none. Thirty-six percent of the children of school age (7 to 15 years, inclusive) had not attended school a single day in the calendar year preceding the study.

MAPPING JOBS FOR TEXAS MIGRANTS, by Lewis T. Nordyke. *Survey Graphic*, Vol. 29, No. 3 (March 1940), pp. 152–157.

By locating areas where workers are needed, and routing workers to these areas, the Texas State Employment Service, a Federal-State agency, is improving the earning power and living conditions of migrant farm workers and their families in Texas. This article describes the program through which the service made 500,000 placements in 1939. The service attempts to anticipate the agricultural needs and to route only enough laborers to handle the work.

FACTORIES ACT, 1937; report on hours of employment of women and young persons in factories during the first 5 months of the war. Home Department, London, 1940. 15 pp. 3d. net.

At the onset of war in September 1939, this report points out, it was widely recognized that the hours worked in the war of 1914–19 had been excessive, that working hours should not exceed 60 a week at most, even as a temporary resort, and that the hours of young workers under 16 should be relatively short. The Service Departments' contractors were notified that, if necessary, employees 16 years of age and over might work overtime subject to a maximum of 60 hours a week, pending orders from the Home Secretary formally authorizing such relaxation of the Factories Act as were found to be necessary. This arrangement was temporary, and authority to employ workers overtime can now be obtained only through the factory inspectors and the Home Office.

To the end of January 1940, orders authorizing extended hours for women and young persons 16 years of age and over had been granted to about 2,500 factories; in most cases the authorized hours did not exceed 57 a week. Permission to employ women over 18 years of age at night had been given in 57 orders.

Under the act, males 16 years of age and over may be employed on night shifts in continuous-process industries; 12 orders had been granted modifying this provision or extending it to noncontinuous processes.

Under the Factories Act of 1937 hours of work for children between 14 and 16 years of age were reduced July 1, 1938, to 48 a week in all factories, and, July 1, 1939, to 44 hours a week, except in cotton and woolen-textile industries. On the outbreak of war, hundreds of applications were received for permission to employ children up to 48 hours a week. After 2 months, however, many employers were able to adjust themselves to the 44-hour week for children; some firms met the difficulty by employing two shifts of children. In industries where boys work closely with older persons as helpers, particularly in shipbuilding and ship repairing, 133 orders permitting boys under 16 to work 47 or 48 hours a week were still in operation in January 1940.

The Children's Bureau *does not distribute* the publications to which reference is made in THE CHILD except those issued by the Bureau itself. Please write to the publisher or agency mentioned for all others.

• EVENTS OF CURRENT INTEREST •

CONFERENCE CALENDAR

July 29–Aug. 2	Great Lakes Institute—Tenth Annual Institute for Social Work Executives, College Camp, Wis. Information: Community Chests and Councils, 155 East Forty-fourth Street, New York.
July 29–Aug. 2	Blue Ridge Institute for Southern Social Work Executives. Fourteenth annual meeting, Blue Ridge, N. C. Information: Community Chests and Councils, 155 East Forty-fourth Street, New York.
Aug. 12–16	National Medical Association. Forty-sixth annual convention, Houston, Tex. General secretary: John T. Givens, M. D., 1108 Church Street, Norfolk, Va.
Sept. 2–5	American Association for Applied Psychology. Fourth annual meeting, Pennsylvania State College, State College, Pa. (Section on clinical psychology is of special interest to persons working with children.)
Sept. 8–9	American Association of Public Health Dentists. Cleveland, Ohio.
Sept. 9–13	American Dental Association. Eighty-second session, Cleveland. Permanent headquarters: 212 East Superior Street, Chicago.
Sept. 16–20	American Hospital Association. Boston, Mass.
Sept. 23–29	Better Parenthood Week. Sponsored by *Parents' Magazine*. Information and program material from Better Parenthood Week Committee, 52 Vanderbilt Avenue, New York.
Sept. 24–28	National Federation of Settlements. Twenty-eighth conference, Pocono Summit, Pa. Permanent headquarters: 147 Avenue B, New York.
Sept. 30–Oct. 4	National Recreation Congress. Twenty-fifth annual congress, Cleveland, Ohio. Permanent headquarters: 315 Fourth Avenue, New York.
Oct. 5–10	National Society for Crippled Children. Annual convention, Asheville, N. C. Permanent headquarters: Elyria, Ohio.
Oct. 7–11	National Safety Council. Chicago. Permanent headquarters: 20 North Wacker Drive, Chicago.
Oct. 8–11	American Public Health Association. Sixty-ninth annual meeting, Detroit. Permanent headquarters: 50 West Fiftieth Street, New York.
Oct. 21–24	American Dietetic Association. Twenty-third annual meeting, New York.

U. S. GOVERNMENT PRINTING OFFICE 1940

THE FOLLOW-UP PROGRAM OF THE WHITE HOUSE CONFERENCE ON CHILDREN IN A DEMOCRACY

Supplement to The Child, Volume 5, Number 1
July 1940

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU
WASHINGTON, D. C.

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THE FOLLOW-UP PROGRAM OF THE WHITE HOUSE CONFERENCE ON CHILDREN IN A DEMOCRACY

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UNITED STATES DEPARTMENT OF LABOR
FRANCES PERKINS, SECRETARY

✦

CHILDREN'S BUREAU
KATHARINE F. LENROOT, CHIEF

Our Concern—Every Child

By Katharine F. Lenroot

The White House Conference on Children in a Democracy has presented to the country a program which will be without meaning unless it is translated into action. Through the organization of the National Citizens Committee, leadership in planning follow-up activities—already initiated in a number of States—has become available. The character of this leadership should give encouragement to groups in all States anxious to do their part.

The National Citizens Committee, working with the Federal Interagency Committee, will serve as a center for exchange of information about State programs, for rallying support for Conference objectives which seem of greatest importance in the present crisis, and for promoting and encouraging the vigorous follow-up activities which are needed in every State.

The task before us is a challenge to every organization, official and voluntary, concerned with the welfare of children and to every citizen of every community, large or small. State programs should be designed to benefit children wherever they may live—in large centers of population or in remote villages and rural areas. Long-range programs and immediate objectives must be based on the needs of "the whole child" and of every child. Specific needs and projects must be considered with regard to the maintenance of proper perspective and balance in the entire program.

In other words follow-up plans must not be short-circuited by overemphasis on special problems and conditions, yet at the same time there must be selection of objectives with reference to both their immediate and their long-time importance and possibility of attainment. These principles are of equal importance in State programs and in community activities. Only through teamwork in planning and carrying out effective and well-coordinated programs can there be steady progress toward the goals of the people of the United States for their children as defined by the Conference.

The urgency of the program outlined by the Conference has been sharpened by the world crisis, which now affects every consideration and every plan. In developing Conference follow-up activities, primary emphasis at certain strategic points is required. Among these are the following:

1. The internal strength and unity of purpose which are essential if our democracy is to be effective in meeting the challenges which it must now face depend to a great extent upon the confidence with which parents can look to democracy to afford security and opportunity for their children. The safety, the health, the homes, and the schools of the children should be protected adequately at whatever cost of resourceful planning and financial sacrifice.

2. Basic public-health and maternal and child-health services, which have received great impetus in the last 5 years under the Social Security Act, should be conserved and extended as necessary to assure the people of this country that the lives and health of mothers and children will not be needlessly sacrificed or impaired for want of health supervision and medical service. In such a program, as well as in economic measures for strengthening the foundations of family life, nutrition should be given an important place, since good nutrition is essential to the physical and mental vigor of the population.

3. The social gains of the last decade which have helped to preserve and strengthen the economic foundations of home life should be maintained and extended. These include fair-labor-standards legislation, and the work-projects, farm-security, and public-assistance programs. General public-assistance and

relief programs throughout the Nation should be strengthened, so that no children will be without adequate shelter, or nourishing food, or warm clothing, or opportunity to attend school.

4. Social services for children of all economic levels needing special assistance in dealing with problems of home, school, or community adjustment should be everywhere available.

5. Child-labor standards should be preserved and strengthened, and protection should be extended to children engaged in industrialized agriculture, especially children of migratory workers.

6. Educational resources should be maintained and augmented as necessary to assure to every child a fair chance for schooling throughout the school-age period.

7. The objectives of the Nation for its youth should be kept broad and sound as training programs for national preparedness are developed. Every needed facility for health protection and for educational and vocational guidance for youth should be provided. Youth with special aptitudes should be afforded opportunity for their full development as their contribution to the strength of the Nation. Opportunity for continued education or useful employment should be assured to all young people, not merely to those engaged in preparedness programs.

Service of children and youth to democracy was stressed by the White House Conference as of equal importance with the service of democracy to the younger generation, which constitutes its hope and its strength. The challenge of the White House Conference is the challenge which the present crisis places before the Nation.

In this period when every resource of the Nation must be placed upon the strongest possible foundation, it is fortunate that the people of this country have been given a positive program of child welfare through the White House Conference on Children in a Democracy. The National Citizens Committee of this Conference at its first meeting, June 17, 1940, adopted a resolution calling upon every citizen and all organizations concerned with human welfare to do their share in helping our democracy serve the needs of every child and prepare children and youth for service to democracy. It is important now that follow-up programs be organized in every State. If they function well, they will affect the well-being of children in every community.

The American people are concerned that the care of our own children be fully adequate, and at the same time that the United States share in extending aid to the children of Europe who have suffered from the terrors of war. The United States Committee for the Care of European Children has urged that there be no slackening in the services for American children, both governmental and private, which must be maintained and expanded wherever they are inadequate. I am confident that we shall not fail our own children or the children of other lands whom it is our privilege to serve.

MARSHALL FIELD,
Chairman, National Citizens Committee.

Child Conservation and National Defense

Declarations of the National Citizens Committee of the White House Conference on Children in a Democracy, June 17, 1940

The National Citizens Committee, created by the White House Conference on Children in a Democracy to give national leadership in making the Conference recommendations effective, is convinced that the program adopted by that Conference will make for the national unity so sorely needed at this time and will strengthen the democratic institutions of our country. The Committee believes that child welfare and national security are inseparable and affirms that—

1. The defense of democracy calls for the appreciation of the dignity and worth of the individual and concern for the young, the helpless, the needy, and the aged. Support of public and private services for children should be sustained as an essential part of a national-defense program.

2. National effectiveness requires further development of cooperation and self-discipline among our citizens. To destroy our liberties in an effort to protect them would be a tragic blunder. Denial of civil liberties, resort to mob action and other extralegal procedures, and throttling of free discussion of public issues will not advance the cause of democracy at home or abroad.

3. To be strong a people must be well-nourished. Proper food for mothers and children depends upon factors such as agricultural production and distribution, maintenance of family income, and education in nutrition.

4. Health services and medical care for all, particularly for mothers, children, and youth, should be maintained and extended.

5. Educational opportunity adapted to present-day needs should be made available to all children, to youth until they secure employment, and to adults as required for vocational efficiency and for citizenship.

6. Standards now provided under Federal and State child-labor laws should be preserved, and similar safeguards should be extended to children needing but not now receiving such protection. The national strength does not need the labor of children.

7. Work opportunities should be made available for all youth who have completed their schooling, with necessary safeguards for their health, education, and welfare.

8. The gains under Federal and State legislation for the conservation of home life for children in need should be maintained and developed, with more active State and local participation.

9. We must consider ways in which we may help to safeguard the children of other lands from such misfortunes as hunger and homelessness. We cannot consider the needs of the children of this Nation and ignore the hardships visited upon children elsewhere.

10. The social gains of the past decade should be maintained in the present critical period. Standards of family living should have an important place in the program of the Advisory Commission to the Council of National Defense. The Advisory Commission should consider ways in which health, educational opportunity, and the social well-being of families and their children may be conserved and advanced as essential elements in a national-defense program.

Resolutions Relating to the Follow-up Program

Adopted by the National Citizens Committee of the White House Conference on Children in a Democracy, June 17, 1940

The National Citizens Committee on Children in a Democracy, appointed to develop and carry out a program for making effective the conclusions and recommendations of the White House Conference—

1. Calls upon every citizen and all organizations and professional associations concerned with human welfare to do their share in helping our democracy serve the needs of every child and prepare our children and youth for service to democracy. To this end it urges:

(*a*) Study of the report and recommendations of the White House Conference on Children in a Democracy.

(*b*) Cooperation in the organization of State-wide activities for making effective in every community the goals of the Nation for its children.

(*c*) Cooperation by public officials, churches, schools, clubs, and all National, State, and local associations and agencies interested in children in advancing toward the goals set by the Conference on Children in a Democracy for the next 10 years.

2. Calls upon the people of the country to maintain and extend essential services for maternal and child health, home conservation and family maintenance, education, child-labor administration and youth guidance, and social protection and care of children to the end that such services may be available as needed to every child and especially to children whose welfare may be threatened by conditions growing out of the world crisis.

While providing all means for defense against those dangers which imperil the existence of our democracy, we must take especial care that children are not deprived of their chance for health, for home life, for an education. The present emergency makes it the more important that we go forward in all ways needed to assure to our children decent homes, nourishing food, health services and medical care, schooling that prepares for citizenship, wholesome recreation, protection against child labor. Above all we must cherish and preserve our respect for the dignity and worth of human personality. The White House Conference on Children in a Democracy looks to those who will carry on State and local follow-up programs to keep steadily before the American people the ways in which democracy must serve its children if they are in turn to preserve democracy.

KATHARINE F. LENROOT,
Chairman, Federal Interagency Committee.

Suggestions for State Follow-up Programs

Approved by the National Citizens Committee of the White House Conference on Children in a Democracy, June 17, 1940[1]

In the Recommendations for a Follow-up Program (see p. 9) adopted by the White House Conference on Children in a Democracy it was recognized that State-wide follow-up activities are of major importance in making the recommendations of the Conference effective. It is planned that the National Citizens Committee shall devote major attention to stimulating and aiding in the development of such programs. It is recognized, however, that the form of organization and the content of the program will vary greatly from State to State. It will be necessary for State committees entrusted with responsibility for follow-up work to determine what specific objectives should be given priority in a developing program and for what parts of the comprehensive program the State White House Conference organization should assume primary responsibility. Following are suggestions for State groups desiring advice in regard to the manner in which a State White House Conference program may be gotten under way.

Some Criteria for Determining Long-Range and Immediate Objectives.

State programs should be planned for a period covering several years and within a broad framework in which specific objectives will be defined and ranked according to priority. It must be kept ever in mind that the main theme of the White House Conference is Our Concern—Every Child. Objectives should be related to several of the following fields, preferably representing both the groups indicated:

Group I. Objectives related chiefly to cooperation and assistance in promoting programs of other organizations giving leadership in these fields:

- Family life
- Economic resources of families and communities
- Economic aid to families
- Housing
- Youth
- Minority groups
- Migrants

Group II. Objectives related to specific programs for children:

- Health
- Education
- Child labor
- Leisure-time services
- Social services for children

Among the factors to be considered in determining objectives and priorities among objectives are the following:

1. Importance as indicated by number of children involved and relation to the child's total development and preparation for citizenship.
2. Relation to emergency conditions created by war-industry employment or other aspects of the world crisis.
3. Stage of development and public interest (e. g., so retarded as to make action urgently necessary; or so advanced as to make rapid progress possible).
4. Availability of leadership and resources for work toward specified objectives.

Possible Steps in State Organization for White House Conference Work.

1. Dissemination of information and copies of reports through members of the Conference and interested groups.
2. Presentation of the program of the Conference at meetings of State and local organizations, professional and citizens' groups.

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[1] For transmission to the committee on State program and State conferences.

3. Tentative proposals for State-wide follow-up plans, developed by a group of interested persons or by an officially constituted committee, and communication of these proposals to the National Citizens Committee. Such proposals in many States might provide for a State citizens' committee and an interdepartmental committee of State officials. In other States a single committee with official and unofficial representation might be more practicable.
4. On receipt of such proposals the National Citizens Committee, through a standing committee on State programs working in cooperation with a similar subcommittee of the Federal Interagency Committee, will review the plans and make suggestions based in part on experience of other States, which will be transmitted by the chairman of the National Citizens Committee to the State group.
5. Further development and carrying out of a State-wide program, including projects such as—
    - (*a*) Review of State conditions in the light of the White House Conference report.
    - (*b*) Development of specific objectives for immediate action and, more tentatively, a long-range program for the State.
    - (*c*) State, regional, or local conferences to consider these objectives and the ways by which they may be furthered.
    - (*d*) Enlistment of the cooperation of State-wide groups.
    - (*e*) Local organization for study and action.

> ***I ask all our fellow citizens who are within the sound of my voice to consider themselves identified with the work of this Conference. I ask you all to study and discuss with friends and neighbors the program that it has outlined, to study how its objectives can be realized. May the security and the happiness of every boy and girl in our land be our concern, our personal concern, from now on.***
>
> FRANKLIN D. ROOSEVELT.
>
> (From an address broadcast at the Conference on Children in a Democracy.)
>
> ***No matter what the storms, no matter what the stresses, no matter what the world problems are, both economic and social problems, it is our intent and purpose to keep our minds firmly fixed upon the welfare of our children and to promote that welfare under all conditions, recognizing that they are the vitality, after all, of this great experiment which we are making upon this continent.***
>
> FRANCES PERKINS.

Recommendations for a Follow-up Program

Adopted by the White House Conference on Children in a Democracy

A report on Plans for Nation-Wide Consideration and Action was presented at the General Session, January 20, 1940, by the chairman of the provisional committee on a follow-up program. The Conference membership present at the meeting voted to adopt the report in substance and referred it to the Planning Committee for final action. The following recommendations were approved:

1. That follow-up work be started at once.

2. That responsibility for national leadership in the follow-up program be placed in a National Citizens Committee and a Federal Interagency Committee on the White House Conference on Children in a Democracy. The National Citizens Committee should be nongovernmental in character, representing organizations and associations that have participated in the work of the Conference. The Federal Interagency Committee should include representatives of Federal agencies that have participated in the Conference activities.

3. That the function of the National Citizens Committee include preparing and disseminating printed, visual, and radio material; enlisting the cooperation of national organizations in studying and furthering the objectives of the Conference; cooperating with governmental agencies in matters relating to the follow-up program; and assisting the States and Territories in the development of State and Territorial programs adapted to the needs and interests of each State.

4. That the Conference request the Federal agencies represented in the membership of the Conference to form a Federal Interagency Committee on the White House Conference on Children in a Democracy, with power to add to its membership, whose functions would include: Interchange of information and coordinated planning on the part of the Federal agencies in matters related to the Conference program; cooperation with the National Citizens Committee; collaboration with such State interagency committees as may be formed; and encouragement of cooperation between the Federal agencies and the State agencies with which they have close relationships in carrying out the objectives of the Conference.

5. That State follow-up programs be inaugurated, adapted to the special problems and circumstances in each State. In making this recommendation the Conference takes note of work already done in reviewing child-welfare conditions in certain States and Territories preparatory to this session of the Conference. Development of State citizens' and interagency committees may be found to be advisable in many States; in others, different methods of organization would be more appropriate. The National Citizens Committee and the Federal Interagency Committee should make available to the States service in developing methods of organizing State follow-up work.

6. That State groups responsible for follow-up programs provide leadership to local communities which desire to organize or expand local programs for determining the ways by which children may be given more adequate care in their homes and through community services.

7. That the Conference authorize the Planning Committee to appoint a group of 5 to take responsibility for organizing and calling together a National Citizens Committee of approximately 15 to 25 members, representative of the interests of labor, industry, agriculture, religion, citizens, and the professions.

8. That the Finance Committee of the Conference be asked to explore the possibilities of financial support of the work of the National

Citizens Committee for a definite period, sufficient to provide adequate leadership and staff assistance, with funds available if possible for assistance in the development of State follow-up programs.

9. That in all States and in local communities existing organizations interested in child welfare participtate to the fullest extent possible, and that National, State, and local organizations stress continuity and progressive development of the services they are prepared to render.

10. That in organizing follow-up programs, National, State, and local, due consideration be given to minority representation in planning and carrying out the follow-up work of the Conference.

National Citizens Committee of the White House Conference on Children in a Democracy

The recommendations adopted by the White House Conference with reference to follow-up activities entrusted responsibility for national leadership to a National Citizens Committee and a Federal Interagency Committee. They stated that the National Citizens Committee should be nongovernmental in character, representing various organizations and associations that have participated in the work of the Conference. The recommendations suggested that the National Citizens Committee should prepare and disseminate printed, visual, and radio materials, enlist the cooperation of national organizations in studying and furthering the objectives of the Conference, cooperate with Government agencies in connection with the follow-up program, and assist the States and Territories in developing programs adapted to the needs and interests of each State.

As the first step toward organization of the follow-up program the Planning Committee of the Conference voted that the Conference chairman, after receiving suggestions from members of the Planning Committee, should appoint five members to form a nucleus of the National Citizens Committee authorized to appoint additional members. The original members of the committee were Homer Folks, chairman; William G. Carr, Mrs. Saidie Orr Dunbar, Henry F. Helmholz, M. D., and Rev. Bryan J. McEntegart.

The first meeting of the National Citizens Committee of the White House Conference on Children in a Democracy was held in New York City on June 17, 1940. At this time the committee numbered 25 members. The executive committee elected at this meeting was empowered to fill vacancies and to add to the membership within limits which may be fixed by the National Citizens Committee. The list of members as of June 17, 1940, is appended.

The bylaws adopted by the committee defined its object as follows:

> The object of the committee shall be to give Nationwide citizens' leadership in developing long-range and immediate programs for carrying into effect the recommendations of the White House Conference on Children in a Democracy, including specifically the following:
>
> (*a*) Cooperation with the Federal Interagency Committee of the White House Conference on Children in a Democracy.
>
> (*b*) Dissemination of information concerning the Conference and its recommendations and follow-up activities.
>
> (*c*) Stimulation and aid in the development of State follow-up programs.
>
> (*d*) Enlistment of the cooperation of voluntary agencies interested in the well-being of children, for the purpose of carrying forward the objectives of the Conference.
>
> (*e*) Consideration of the special needs of children growing out of emergency conditions, and cooperation with other organizations engaged in conserving and advancing the health, education, home care, and social protection of children under such conditions.

The following officers and members of the executive committee were elected:

Chairman	Marshall Field.
Vice chairman	Homer Folks.
Secretary	M. O. Bousfield, M. D.
Treasurer	James E. West.

Executive committee: Chairman and vice chairman (ex officio), William G. Carr, Mrs. Saidie Orr Dunbar, Henry F. Helmholz, M. D., William Hodson, Reverend Bryan J. McEntegart, Charles W. Taussig, and Rabbi Abba Hillel Silver.

Standing committees were authorized as follows:

Finance committee,
  Charles W. Taussig, chairman.
Committee on State programs and State conferences,
  William G. Carr, chairman.
Committee on national agency programs,
  Emma C. Puschner, chairman.
Committee on informational material:
  Frank G. Boudreau, M. D., chairman;
    Subcommittee on motion pictures,
      Melvyn Douglas, chairman.
Committee on emergency and special programs,
  William Hodson, chairman.

The National Citizens Committee adopted declarations on Child Conservation and National Defense (see p. 5) and Resolutions Relating to the Follow-up Program (see p. 6). It also approved Suggestions for State Follow-up Programs (see p. 7).

An annual budget tentatively planned for continuance of activities for at least 3 years was adopted provisionally, subject to obtaining the necessary funds. In the meantime the committee authorized immediate inauguration of the program, utilizing limited funds which will be available for the next 3 months, and temporary headquarters have been established at 105 East Twenty-second Street, New York, in the offices of the New York State Charities Aid Association.

Members of the National Citizens Committee of the White House Conference on Children in a Democracy

June 17, 1940

Mrs. H. W. Ahart, president, Associated Women of American Farm Bureau Federation, Lincoln, Calif.

Chester I. Barnard, president, New Jersey Bell Telephone Co., Newark, N. J.

Frank G. Boudreau, M. D., executive director, Milbank Memorial Fund, New York, N. Y.

M. O. Bousfield, M. D., director for Negro health, Julius Rosenwald Fund, Chicago, Ill.

Charles Gardner Bullis, president, Council of Social Agencies, Los Angeles, Calif.

William G. Carr, secretary, Educational Policies Commission, National Education Association, Washington, D. C.

Donald Comer, Avondale Mills, Birmingham, Ala.

Dorothy Deming, general director, National Organization for Public Health Nursing, New York, N. Y.

Melvyn Douglas, Los Angeles, Calif.

Mrs. Saidie Orr Dunbar, president, General Federation of Women's Clubs, Portland, Oreg.

Marshall Field, New York, N. Y.

Homer Folks, secretary, State Charities Aid Association, New York, N. Y.

George Harrison, vice president, American Federation of Labor, Cincinnati, Ohio.

Henry F. Helmholz, M. D., professor of pediatrics, Graduate School, University of Minnesota, Rochester, Minn.

Sidney Hillman, president, Amalgamated Clothing Workers of America, New York, N. Y.

William Hodson, commissioner of public welfare of the City of New York, New York, N. Y.

The Most Reverend Charles H. LeBlond, Bishop of St. Joseph, St. Joseph, Mo.

Reverend Bryan J. McEntegart, director, Division of Children, Catholic Charities of the Archdiocese of New York, New York, N. Y.

Mrs. J. K. Pettengill, Detroit, Mich.
(Former president, National Congress of Parents and Teachers.)

Emma C. Puschner, director, National Child Welfare Division, American Legion, Indianapolis, Ind.

Floyd W. Reeves, director, American Youth Commission, Washington, D. C.

Rabbi Abba Hillel Silver, The Temple, Cleveland, Ohio.

Charles W. Taussig, president and chairman of board, American Molasses Co., New York, N. Y.

James E. West, chief scout executive, Boy Scouts of America, New York, N. Y.

William Allen White, editor and author, Emporia, Kans.

The following were invited by the National Citizens Committee to attend all meetings of the Committee and to cooperate in its work:

Frank Bane, executive director, Council of State Governments.

Fred K. Hoehler, director, American Public Welfare Association; designated by the Federal Interagency Committee to serve as liaison agent with the National Citizens Committee.

Katharine F. Lenroot, Chief, Children's Bureau, U. S. Department of Labor; chairman, Federal Interagency Committee, White House Conference on Children in a Democracy.

Federal Interagency Committee of the White House Conference on Children in a Democracy

Purpose of the Committee and Organization of Activities

Plans for the organization of a Federal Interagency Committee were the outgrowth of action by the White House Conference on Children in a Democracy at the closing session. On March 20, 1940, President Roosevelt addressed the following letter to Secretary Perkins, chairman of the White House Conference:

> The honorable the SECRETARY OF LABOR.
>
> MY DEAR MISS PERKINS: I am heartily in agreement with the recommendation of the White House Conference on Children in a Democracy adopted at its closing session, January 20, that a Federal Interagency Committee be formed with power to add to its membership, whose functions would include interchange of information and coordinated planning on the part of the Federal agencies in matters related to recommendations for action adopted by the Conference; cooperation with the National Citizens Committee, which I understand is now being organized; and cooperation with such State interagency committees as may be formed.
>
> I suggest that as chairman of the Conference you invite the agencies which have participated in its work to designate representatives to serve on a Federal Interagency Committee. It would seem to me appropriate that the Chief of the Children's Bureau, who served as executive secretary of the Conference, be requested to provide the necessary staff service for the interagency committee.
>
> Sincerely,
>
> FRANKLIN D. ROOSEVELT

In accordance with this authorization, letters were sent by Secretary Perkins to the heads of 30 Federal agencies asking them to meet for the purpose of organizing the Federal Interagency Committee. Representatives of 26 of these agencies met on April 5, 1940, to discuss organization of a permanent committee and proposed activities. The meeting authorized appointment of an organization committee to report to a later meeting: (a) To make recommendations in regard to the permanent organization of the Federal Interagency Committee, with special reference to purpose, functions, and membership; (b) to nominate permanent officers of the committee; (c) to nominate members of a small executive or planning committee; and (d) to make recommendations regarding other standing committees as indicated by the general discussion at the meeting and the plans already developed for the National Citizens Committee.

The second meeting of the group of representatives of Federal agencies was held May 6, 1940, with 24 agencies represented.

The following statement of the purpose and functions of the Federal Interagency Committee, recommended by the organization committee, was adopted:

> That a Federal Interagency Committee be formed with power through its executive committee to add to the membership representatives of such other Federal agencies as may make a contribution to the work of the committee; whose functions shall include interchange of information and coordinated planning on the part of the Federal agencies in matters related to recommendations for action adopted by the Conference; cooperation with the National Citizens Committee, and with such other agencies as may be concerned with matters in connection with the White House Conference on Children in a Democracy.

The following recommendations were adopted with reference to officers and committees:

Officers.—The permanent officers of the committee shall consist of a chairman, a vice chairman, and a secretary.

Executive committee.—An executive committee shall be elected to consist of from four to six members of the Federal Interagency Committee, in addition to the officers who shall act as ex officio members of the executive committee.

It shall be the duty of the executive committee to act between meetings of the Federal

Interagency Committee and to help in developing the work of the committee.

Standing committees shall include—

(*a*) Committee on information service;
(*b*) Committee on State cooperation (to work with corresponding committee under the National Citizens Committee);
(*c*) Committee on information to field services of Federal agencies.

The executive committee shall be empowered to organize committees along these lines and such others as may be considered necessary and to appoint the personnel of these committees. The following officers were elected:

Chairman	Katharine F. Lenroot, Children's Bureau.
Vice chairman	Carl C. Taylor, Bureau of Agricultural Economics.
Secretary	Bess Goodykoontz, U. S. Office of Education.

Members of the executive committee:

The officers, ex officio.
Jane Hoey, Bureau of Public Assistance, Social Security Board.
Mrs. Florence Kerr, Work Projects Administration.
Surgeon General Thomas Parran, Public Health Service.
Louise Stanley, Bureau of Home Economics.
M. L. Wilson, Extension Service.
Representative of National Youth Administration.

The group adopted the recommendation that Fred K. Hoehler, director of the American Public Welfare Association, be appointed to serve on the Federal Interagency Committee as a liaison agent between the National Citizens Committee and the Federal Interagency Committee.

Members of the standing committees, as recommended by the organization committee, will be appointed by the executive committee.

Among the proposals made by the group were: Preparation of a combined list of Government publications in the field of child welfare or related to it; selection of publications by the various Government departments which may be of service in connection with the follow-up programs of the States; and preparation of special publications adapted for use in follow-up activities, dividing publications into two groups, popular and technical in character. At the request of a number of the Federal agencies, White House Conference publications and other material have been supplied to staff members engaged in field work in the various States, in order to keep them informed of the objectives of the Conference and plans for follow-up work.

Federal Interagency Committee

of the White House Conference on Children in a Democracy

June 15, 1940

Executive Office of the President:
  Central Statistical Board,
    P. K. Whelpton, consultant on population research (observer).
  National Resources Planning Board,
    Eveline M. Burns, director of research, Technical Committee on Long-Range Work and Relief Policies (observer).
Federal Communications Commission,
    John B. Reynolds, Assistant Secretary.
Federal Housing Administration,
    Richard R. Quay, senior attorney.
Federal Security Agency:
  Civilian Conservation Corps,
    Guy D. McKinney, assistant to the Director.
  U. S. Office of Education,
    Bess Goodykoontz, Assistant Commissioner.
  National Youth Administration,
    Mary H. S. Hayes, Director, Division of Employment.
  Public Health Service,
    Thomas Parran, Surgeon General.
  Social Security Board:
    Bureau of Employment Security,
      Ewan Clague, Director.
    Bureau of Old-Age and Survivors Insurance,
      John J. Corson, Director; Alternate: Merrill G. Murray, Assistant Director.
    Bureau of Public Assistance,
      Jane M. Hoey, Director.
    Bureau of Research and Statistics,
      Isidore S. Falk, Acting Director; Alternate:
        Anne E. Geddes, Chief, Division of Public Assistance Research.
Federal Works Agency:
  U. S. Housing Authority,
    Blanche Halbert, consultant, research and statistics.
  Work Projects Administration,
    F. C. Harrington, Commissioner; Alternate: Mrs. Florence Kerr, Assistant Commissioner.

- Interdepartmental Committee To Coordinate Health and Welfare Activities,
    - Josephine Roche, chairman; Alternate: Martha M. Eliot, M. D., chairman, Technical Committee on Medical Care.
- U. S. Department of Agriculture:
    - Agricultural Adjustment Administration,
        - Mrs. Minnie Fisher Cunningham, specialist in information.
    - Bureau of Agricultural Economics,
        - Carl C. Taylor, Head, Division of Farm Population and Rural Welfare.
    - Office of Experiment Stations,
        - Sybil L. Smith, Principal Experiment Station Administrator.
    - Extension Service,
        - Mrs. Lydia Ann Lynde, extension specialist in parent education and family life.
    - Farm Security Administration,
        - T. J. Woofter, Jr., economic adviser.
    - Federal Surplus Commodities Corporation,
        - Richard R. Brown, in charge, State Distribution Section.
    - Bureau of Home Economics,
        - Louise Stanley, Chief.
- U. S. Department of Commerce:
    - Bureau of the Census,
        - Vergil D. Reed, Assistant Director.
- U. S. Department of the Interior:
    - Office of Indian Affairs,
        - Willard W. Beatty, Director, Education Division.
    - National Park Service,
        - Arno B. Cammerer.
- U. S. Department of Justice:
    - Bureau of Prisons,
        - James V. Bennett, Director.
- U. S. Department of Labor:
    - Children's Bureau,
        - Katharine F. Lenroot, Chief.
    - Division of Labor Standards,
        - Verne A. Zimmer, Director.
    - Bureau of Labor Statistics,
        - Aryness Joy, assistant to the Commissioner; Alternate: Edwin M. Martin, economist.
    - Women's Bureau,
        - Mary Anderson, Director.

Fred K. Hoehler, director, American Public Welfare Association, Chicago, Ill., to serve as liaison agent between National Citizens Committee and Federal Interagency Committee.

PUBLICATIONS

Single copies of the publications listed below may be obtained free from the Children's Bureau, U. S. Department of Labor, Washington, D. C., while the supply lasts. Additional copies may be purchased from the Superintendent of Documents at the prices listed or at a discount of 25 percent on orders of 100 or more copies. Purchase orders should be sent to the Superintendent of Documents, Government Printing Office, Washington, D. C.

WHC–A_____ Conference on Children in a Democracy—Papers and Discussions at the Initial Session, April 26, 1939. Children's Bureau, Washington, 1939. 117 pp.

WHC–B_____ Children in a Democracy—General Report Adopted by the White House Conference on Children in a Democracy, January 19, 1940. Children's Bureau, Washington, 1940. 86 pp.

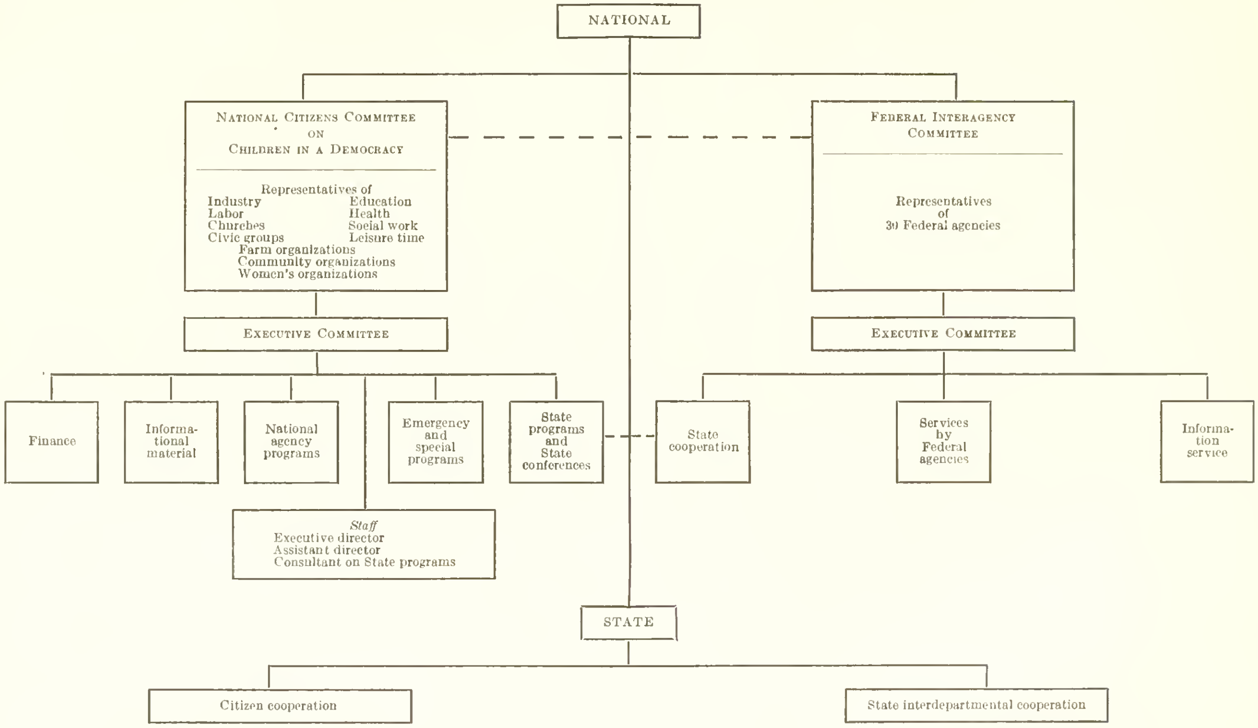
WHC–C_____ Preliminary Statements of the White House Conference on Children in a Democracy; prepared for the use of the Report Committee, presented to group meetings, January 18, 1940, and revised in the light of suggestions received. Children's Bureau, Washington, 1940. (In press.) Contents: The Economic Resources of Families and Communities; Economic Aid to Families; Housing the Family; Religion and Children in a Democracy; Education Through the School; Leisure-Time Services for Children; Library Service for Children and Youth; Child Labor and Youth Employment; Health and Medical Care for Children; Social Services for Children; Children in Minority Groups.

WHC–D_____ Proceedings of the Conference on Children in a Democracy, held in Washington, D. C., January 18–20, 1940. Children's Bureau, Washington, 1940. (In preparation.)

June 17, 1940

WHITE HOUSE CONFERENCE ON CHILDREN IN A DEMOCRACY

Tentative Plan for Follow-up Organization



U. S. GOVERNMENT PRINTING OFFICE: 1940

the CHILD

Monthly Bulletin

A HILLBILLY TRIO IN HAWAII

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

AUGUST 1940

DEPARTMENT OF DOCUMENTS
SEP 18 1940

THE CHILD

MONTHLY BULLETIN

Volume 5, Number 2 August 1940

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Child Labor in Vegetable Canneries in Maryland

By Caroline E. Legg and Ella Arvilla Merritt
Industrial Division, U. S. Children's Bureau

Canning of perishable products has been for many years an industry characterized by employment of children and young persons—employment often unregulated because of the tendency to exempt canneries from State legislation governing employment of children and women.[1] Moreover, the seasonal nature of the industry, requiring a large labor force for only a short time, brings pressure on employers to disregard labor standards in order to recruit workers rapidly. At the same time the short seasons and the isolation of many plants often make enforcement of legislative restrictions difficult. Long hours of work and low earnings are also characteristic of the industry.

For these reasons the prevalence of employment of young persons in canneries has always been a matter of concern to the Children's Bureau and to other agencies interested in child welfare. In June 1938 when the Children's Bureau was made responsible for the enforcement of the child-labor provisions of the Fair Labor Standards Act, which became effective the following October, child labor in canneries became a problem of immediate and special importance to the Bureau. Since a large proportion of the products of the industry are shipped in interstate commerce, these provisions, which included a basic 16-year minimum age for employment, applied to most canneries throughout the country, and the Bureau recognized that first-hand information regarding employment of young workers in canneries would be of great value in meeting the administrative problems likely to arise. To obtain such information the Children's Bureau therefore cooperated in a survey of wages and hours of cannery employees that was being carried on in the summer of 1938 by the Women's Bureau of the Department of Labor.

The Children's Bureau survey dealt with the employment in 1937 and 1938 of young workers under 18 years of age in 48 Maryland vegetable canneries—6 in Baltimore, 16 in northern Maryland, and 26 on the Eastern Shore. As measured by employment figures for the maximum-pay-roll week in 1937, 17 were large plants employing more than 200 workers; 15 were medium-sized plants with a maximum of 100 to 200 employees, and 16 were small plants with less than 100 workers on the pay roll at any time in that year. For 1937 the study covered young workers in these canneries at any time during the year; for 1938, only those employed during peak weeks in selected products.

With the primary purpose of aiding in the administration of the minimum-age provisions of the Fair Labor Standards Act the Children's Bureau survey placed special emphasis on the extent to which children misrepresent their ages to employers and on the value of the employment-certificate system in maintaining a minimum-age standard. Long experience in the administration of child-labor laws has indicated the necessity, in bringing about such enforcement, of a well-developed employment-certificate system that requires employers to obtain certificates for all young workers whose ages are within 2 years above the minimum age for employment. This necessity was clearly demonstrated by the results of the present study.

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[1] The extent of exemption of canneries from labor legislation is much less at the present time than it has been in the past.

MISREPRESENTATION OF AGE

The ages of all workers shown by employers' records as being under 19 years of age[2] were verified by comparison with vital-statistics records, with employment-certificate records in the Baltimore office of the State Commissioner of Labor, and with other sources. The results of this verification emphasize the unreliability of unsupported statements of age given to employers, especially when an incentive to overstatement is supplied by a legislative barrier to employment under a certain age. Of 1,223 children who were found to have been under 18 years of age at the beginning of work in 1937, and for whom the employer had a specific age record, 324, 26 percent, had represented themselves as being older than they actually were. Nearly half of the 419 children under 16 had overstated their ages, 135 by 1 year, 52 by 2 years, and 18 by 3 years or more. The proportion of those 16 and 17 years of age who had overstated their ages was much smaller, about 15 percent. For this group the incentive to overstatement was much less, since the general minimum-age, the employment-certificate, and the hours-of-labor requirements of the Maryland child-labor law[3] do not apply to children after they have reached 16 years of age. The value of the employment-certificate system is shown by reference to the children under 16, for whom the Maryland law required employment certificates. Of the 419 children actually under 16 years of age at the beginning of work in 1937, for whom employers had age records, 49 percent had overstated their ages, whereas for the 128 children of this group who

TABLE 1.—*Misrepresentation of age among minors under 18 years of age working in selected Maryland vegetable canneries, 1937*

Age	Total minors under 18 years	No record of age	Record of age held by employer							
			Total	Age correct	Age overstated					Age understated
					Total		1 year	2 years	3 years or more	
					Number	Percent				
Total	1, 232	9	1, 223	877	324	*26*	237	69	18	22
Under 16 years	420	1	419	208	205	*49*	135	52	18	6
Under 14 years	21	------	21	2	19	([1])	9	5	5	------
14 years	136	------	136	76	58	*43*	17	30	11	2
15 years	263	1	262	130	128	*49*	109	17	2	4
16 and 17 years	812	8	804	669	119	*15*	102	17	------	16
16 years	454	4	450	354	83	*18*	66	17	------	13
17 years	358	4	354	315	36	*10*	36	------	------	3

[1] Percent not computed because total number is too small to make percentage significant.

---

[2] In order to include all minors under 18 years of age, data were obtained from the plants for all minors reported to be under 19, on the supposition that some would claim to be 18 who were in fact younger. Ages were later verified and all minors 18 or over were excluded from consideration in the report.

[3] The Maryland child-labor law establishes a minimum age of 14 years and requires employment certificates for employment of children 14 and 15 years of age. For children 14 and 15 years of age in manufacturing industries, except in canning and packing establishments, it also establishes an 8-hour day, 48-hour week, and 6-day week, and prohibits night work. Employment of children under 16 is prohibited in a number of hazardous occupations, including the operation of power-driven machinery. In addition the employment of children under 18 is prohibited in a number of occupations subject to accident or health hazards. The workmen's compensation law requires payment of double compensation in case of injury to minors illegally employed, but since the hazardous occupations to which the minimum age of 18 applies are seldom found in canneries the effect of this double compensation on cannery employment is practically limited to children under 16.

had employment certificates, the age as given on the certificate was correct in nearly every case.

In 1938 improved enforcement of the requirement for certificates for employed children under 16 changed the picture for the whole group: 59 percent of the children under 16 working for the first time in 1938 had employment certificates, which in every case gave the correct age, compared with only 30 percent in 1937; and only 30 percent had overstated their ages, compared with 49 percent in the group under 16 working in 1937.

The need for a certificate requirement is likewise evident in the overstatements of age by 15 percent of the 16- and 17-year-old minors working in 1937. The Maryland law does not require that employment certificates be obtained for minors 16 years of age and over, but, at the time of the study, certificates of age were being issued on request in some localities for workers of this age group.[4] The value of such certificates as proof of age is shown by the fact that the age was correctly stated in practically every case where certificates of age were on file for workers 16 and 17 years of age.

Occupations, Wages, and Hours of Young Cannery Workers

Detailed information as to canning operations performed by children of various age levels, hours of labor, and earnings for minors under 18 during a particular pay period was obtained only for 1938; that is, for the season immediately preceding the effective date of the Fair Labor Standards Act. The data were taken from pay rolls, the information as to occupations being supplemented by interviews with employers. The four main products covered by the study in 1938 were string beans, tomatoes, corn, and peas. The ages of the 488 children found to be working on these products are shown in table 2.[5]

The percentage of these minors who were under 16 was 37 for those working on string beans; 57 for those working on tomatoes; and 30 for those working on corn. The proportion of children under 16 working on peas was smaller, but even in this work a little more than a tenth of the workers under 18 years of age were under 16.

Occupations.

Much of the routine hand work in canneries is of a type that can be done by young persons—by 14- and 15-year-old boys and girls as well as those 16 and 17 years of age. The largest proportion of the young workers were recorded on the pay rolls as "general laborers," a term which includes most of the hand occupations in the preparation and canning of vegetables, but for a considerable number the specific kind of work done was indicated. More girls than boys were employed in canning tomatoes and string beans; more boys than girls in canning corn and peas. There was a decided difference in the types of occupations of boys and of girls. Girls snipped, inspected, and graded beans, peeled tomatoes, husked corn, and packed peas; boys handled the empty cans in the lofts, dropping them into the chutes for transfer to the sterilizing and filling machines or unloading them from the freight cars and packing them in boxes or conveyors before they were taken to the lofts; or they boxed and prepared goods for shipment. Both boys and girls worked as labelers, pasting labels on cans.

TABLE 2.—*Number and age of minors under 18 working on specified products, 1938*

Product	Age of minor			
	Total	Under 14 years	14 and 15 years	16 and 17 years
String beans	227	3	80	144
Tomatoes	100	1	56	43
Corn	106	2	30	74
Peas	91	------	10	81

Hours of Labor.

In all the cannery processes covered by the study the perishability of the crop and variations in the time of ripening result in long hours during peak periods and a high degree of irregularity in employment. Moreover, the hours-of-labor provisions of the Maryland laws relating to the employment of women and children do not apply to canning and packing establishments.

---

[4] Since the effective date of the Fair Labor Standards Act, October 24, 1938, certificates of age have been made available for minors 16 years of age and over throughout the State.

[5] For 1938 the work period covered was the week of the maximum output of an important product of the establishment. Some children worked on more than one product.

As the pay-roll periods chosen were the peak weeks for each product the hours and earnings of minors were typical of the few weeks in the rush season in the canning of the particular product. In canneries where many products are handled, the rush weeks may succeed one another through a considerable period.

For workers on a piece basis, hours of work were not recorded. The piece-work operation in which the largest number of children were working was the peeling of tomatoes. On this job the worker was paid according to the number of buckets of tomatoes peeled. In the canning of string beans, corn, and peas, most of the work was done on a time basis, and the hours of a large proportion of the young workers were obtained.

Of the young persons under 18 working on string beans for whom hours were recorded, practically half worked more than 48 hours a week, and nearly a tenth worked 60 hours or more; among those working on peas, more than two-fifths worked longer than 48 hours, and more than one-fifth worked 60 hours or more. Long hours were more prevalent in the canning of corn than in any other product, 61 of the 85 minors whose hours were reported (72 percent) having worked more than 48 hours. The median work week for minors working on corn was 56.3 hours; 32 minors under 18 years of age worked 60 hours or more—24 of them working between 60 and 80 hours, 4 between 80 and 90 hours, 3 between 90 and 100 hours, and 1 for 107½ hours. Of those working as much as 80 hours a week, none were under 16 years of age, but 16 children under 16 years worked between 48 and 60 hours, and one 15-year-old girl worked 77½ hours.

Earnings.

Hourly earnings.—For young workers paid on a time basis hourly rates of pay varied considerably with locality and product. Rates of 22½ to 27½ cents an hour were typical. A rate of about 5 cents an hour less for girls than for boys was usual in all products.

Weekly earnings.—In spite of the prevailing long hours, the weekly earnings of children under 18 years of age during the peak week studied were for the most part low. Median earnings ranged from $6.54 for work on tomatoes to about $10.50 for work on string beans and peas and $11.82 on corn. More than a third of the minors under 18 working on tomatoes earned less than $5 a week and less than a tenth earned as much as $15. In canning corn, earnings were somewhat higher, in part because of the longer hours worked on that crop; about two-fifths of the workers earned between $10 and $15 and a third, $15 or more. Among those working on string beans and peas, the percentage earning less than $10 was approximately the same, slightly more than two-fifths, but the percentage of those working on peas who earned as much as $15 was considerably larger than the corresponding percentage of those working on string beans. The very long hours of some of the pea workers were responsible

TABLE 3.—*Weekly hours of minors under 18 years of age working on specified products, 1938*

Weekly hours	Minors under 18 years of age working on—						
	String beans		Tomatoes	Corn		Peas	
	Number	Percent	Number [1]	Number	Percent	Number	Percent
Total	227	----	100	106	----	91	----
Hours reported	227	*100*	28	85	*100*	88	*100*
Less than 40	90	*40*	8	13	*15*	33	*37*
40, less than 44	18	*8*	2	6	*7*	6	*7*
44, less than 48	5	*2*	2	5	*6*	9	*10*
Exactly 48 hours	2	*1*	----	----	----	2	*2*
More than 48, less than 54	79	*35*	4	12	*14*	5	*6*
54, less than 60	12	*5*	10	17	*20*	14	*16*
60 or more	21	*9*	2	32	*38*	19	*22*
Hours not reported	----	----	72	21	----	3	----
Median hours	48.0	----	----	56.3	----	46.2	----

[1] Percents and median not shown because the total number for whom hours are reported is too small to make the distribution significant.

TABLE 4.—*Weekly earnings of minors under 18 years of age working on specified products, 1938*

Weekly earnings	Minors under 18 years of age working on—							
	String beans		Tomatoes		Corn		Peas	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	227	-----	100	-----	106	-----	91	-----
Weekly earnings reported	227	*100*	96	*100*	99	*100*	91	*100*
Less than $5	18	*8*	35	*36*	7	*7*	11	*12*
$5 less than $10	75	*33*	40	*42*	20	*20*	29	*32*
$10 less than $15	123	*54*	12	*13*	38	*39*	34	*37*
$15 or more	11	*5*	9	*9*	34	*34*	17	*19*
Weekly earnings not reported	-----	-----	4	-----	7	-----	-----	-----
Median weekly earnings	$10.47		$6.54		$11.82		$10.61	

for the larger earnings by a part of that group, 22 percent working 60 hours or more compared with 9 percent of those employed on string beans.

SUMMARY

Many children under 18 years of age and some under 16 years of age were employed in vegetable canneries in Maryland in 1937 and 1938 and, on the whole, their hours of labor were long and their earnings low. Approximately one-third of the employees under 18 in the canneries covered by the study in 1938 were under 16 years of age. The median hours for workers under 18 years of age ranged from 46 a week in pea canneries to 56 a week in corn canneries, and their median earnings for the peak week ranged from $6.54 in tomato canneries to $11.82 in corn canneries.

The survey shows conclusively that employers cannot rely on minors' statements of age in deciding whether they are complying with a legal minimum-age standard and that employment certificates should be required for all employed minors for at least a 2-year period above the minimum age for employment. A large proportion of the young workers under 18 covered by this study, particularly of those under 16, had represented themselves as being older than they actually were.

• BIRTH • • GROWTH • • CHILD HEALTH •

Increase in Registration of Crippled Children in Minnesota

January 1937 to January 1940

By H. E. Hilleboe, M. D.,[1] and R. N. Murdoch[2]

Although the Bureau for Crippled Children in Minnesota was started in June 1936 it was not until the first of January 1937 that a current register of known crippled children was established on a State-wide basis. The number of crippled children at that time included all known crippled children under 21 years of age, diagnosed by a physician as having a crippling condition as defined by the Bureau for Crippled Children, Division of Social Welfare, State of Minnesota.

The 5,718 crippled children known to the Bureau on January 1, 1937, consisted mainly of children on the registers of public hospitals and the Shriners' Hospital for Crippled Children. On January 1, 1940, 9,801 crippled children were known to the Bureau. This represents an actual increase of 4,083 crippled children registered and a relative increase of 71 percent in registration.[3]

The number of known crippled children under 21 years of age per 1,000 population under 21 was determined for each county, and a map was prepared showing the distribution of rates by county. The usual method of establishing class intervals and then allocating the counties to these class intervals was reversed, in order to simplify comparison of rates by counties. The counties were listed in rank order of their rates of known crippled children. By dividing the 87 counties into three equal groups of 29 counties each, the upper interval of higher rates, the middle interval of rates near the mean, and the lower interval of lower rates, were established. The twenty-ninth county had a rate on January 1, 1937, of 7.35, and the fifty-ninth county had a rate of 4.11. Any county with a rate of 7.35 or more was placed in the upper interval; any county with a rate from 4.12 to 7.34 was placed in the middle interval; and any county with a rate of 4.11 or less was placed in the lower interval.

This arrangement (map 1) showed a heavy concentration of known crippled children in the northern half of the State, while in the southern half there were only a few scattered counties whose rates of known crippled children were high enough to fall in the upper interval. There may be an economic explanation for this distribution. The southern half of Minnesota falls in the prairie belt. The farms there are prosperous, and many of the residents of this section have not found it necessary to come to the welfare agencies for assistance. On the other hand, the northern half of the State is largely cut-over land, in some cases submarginal and poor for farming. It was in this latter area that the field work of locating crippled children was done prior to the establishment of the Bureau for Crippled Children under the Federal Social Security Act in 1936.

---

[1] Medical coordinator, Department of Social Security, State of Minnesota.

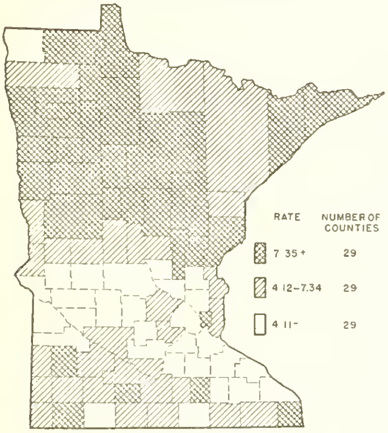
[2] Medical research assistant, Bureau for Crippled Children, Division of Social Welfare, State of Minnesota.

[3] As used in this article, the term "register" includes not only the 9,038 crippled children for whom information was complete as of December 31, 1939, but also 763 whose county of residence was known but whose records were not complete.

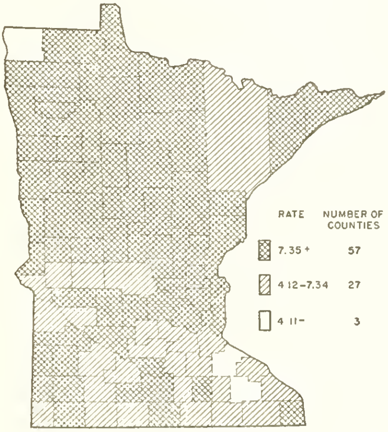
CRIPPLED CHILDREN REGISTERED IN MINNESOTA BY COUNTY, 1937-40

(Per 1,000 population under 21 years of age)

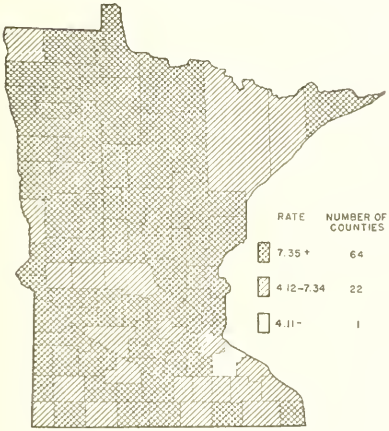
MAP 1.—JANUARY 1, 1937



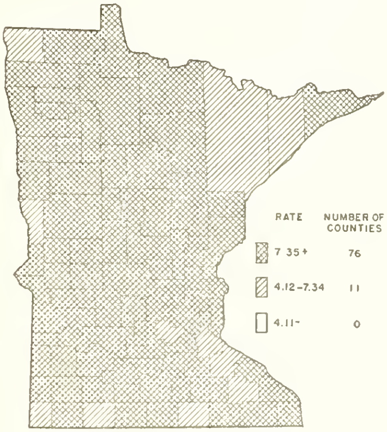
MAP 2.—JANUARY 1, 1938



MAP 3.—JANUARY 1, 1939



MAP 4.—JANUARY 1, 1940



On January 1, 1938, the rates of known crippled children by county were computed again and the counties arranged in order of the rates of known crippled children. When the same rates for segregating the counties into three groups were used as in 1937, there were no longer three equal groups of 29 counties each. Map 2 shows 57 counties in the upper interval in 1938, 27 counties in the middle interval, and only 3 remaining in the lower interval.

Map 3 shows the shift that occurred during the next calendar year. On January 1, 1939, 64 counties had a rate of 7.35 or more; 22 counties had a rate between 4.12 and 7.34; and only 1 county had a rate of 4.11 or less.

Map 4 shows that on January 1, 1940, at the end of the 3-year period, the number of counties with a rate of 7.35 or more had increased to 76; that only 11 counties had a rate between 4.12 and 7.34; and that no counties remained in the lower interval. On January 1, 1940, only two counties—Goodhue and Lake—had rates below 6.0 per 1,000 population under 21, the figure commonly quoted [4] as being the estimated average rate through the country as a whole.

Two factors are thought to be largely responsible for this large increase in the rate of known crippled children in Minnesota: First, the field nursing service; and, second, the itinerant field diagnostic and follow-up clinics. The field nursing service has concentrated on locating new cases by working in close cooperation with general practitioners, local nurses, welfare workers, school teachers, and religious workers in the actual field of operation which embraces the local community and rural homes. The statistical staff of the Bureau for Crippled Children provided the nurses with a valuable administrative tool by making statistics available on a district basis to each district nurse so that she could plan her work accordingly. Maps were prepared showing which counties had low rates, with the implication that many crippled children were not yet located and that something should be done to ferret out new cases.

On January 1, 1940, the mean rate for the State was 9.55 per 1,000 population under 21. The county with the lowest rate had a rate of 4.83, and the second had a rate of 4.88. The highest county rate was 17.34 and the second highest, 16.63. Considering these figures, there is scant statistical justification for assuming that all the crippled children had been located in the two low-rate counties.

In 1937 the field nursing service was instrumental in bringing 269 children to the 13 field clinics for examination; in 1938 the new cases numbered 293 at 14 clinics; and in 1939, there were 283 new cases at 14 field clinics, all in rural areas.

Field nursing services and itinerant rural clinics are effective public-health tools in finding untreated crippled children in rural areas, soon after crippling has occurred. Prevention of further deformity and disability in children already crippled, who have lapsed in their treatment, is accomplished by the follow-up work of these two services in the field, which results in the return of former patients to the clinic and hospital for complete and adequate medical care.

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[4] *Ed. note.*—In "Crippling Conditions Found Among Children on State Registers, December 31, 1939" (p. 4), the Children's Bureau published data from 51 State registers of crippled children, which indicated that earlier estimates may have been too low. *Social Statistics,* Supplement to *The Child,* Vol. 4, No. 12.

The Poliomyelitis Epidemic in Charleston County, S. C.

By Margaret S. Arey, R. N.

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In May 1939 there was being reported each week to the health department in Charleston County, S. C., an average of 17 cases of poliomyelitis. The staff nurses were answering three times the usual number of morbidity calls because of the increasing number of positive and suspected cases. Poliomyelitis cases were being found in the rest of the State also, but in no other section of the State was such a consistently high rate of positive cases being reported.

At the suggestion of the United States Children's Bureau the State health officer, Dr. James Hayne, requested two agencies that had on their staffs public-health nurses who had had extensive experience in orthopedic nursing, including the care of patients with poliomyelitis, to assist the State orthopedic consultant nurse in handling the ever-increasing case load of new poliomyelitis patients. The employment of two nurses from the Community Health Association in Boston and two from the New York State Department of Health was made possible through the cooperation of these two agencies in releasing the nurses and through the financial assistance provided by the National Foundation for Infantile Paralysis and the United States Children's Bureau. (Funds furnished by the Children's Bureau were made possible through the provisions of the Social Security Act.) The writer was stationed in Charleston County, and the other three nurses were placed at various strategic points in the State.

In the city of Charleston is located the county health department, with Dr. Leon Banov at its head, and with Ellie C. Nelson, R. N., in charge of the 12 nurses on the staff. These nurses are assigned to the city of Charleston and the rest of the county. There is also 1 nurse for communicable-disease service. Roper Hospital, also in Charleston, has an out-patient department where the patients return for follow-up at the orthopedic clinic, of which Dr. F. A. Hoshall is the head. Dr. Hoshall is one of the 5 orthopedic surgeons who carry out the work of the Crippled Children's Division in the State.

Charleston County covers an area of 880 square miles, exclusive of the coastal marsh. Throughout the poliomyelitis epidemic (from November 1938 to September 1939) the cases were about evenly divided between Charleston and the rest of the county, and there was almost an equal proportion of colored and white patients. The peak of the epidemic was in May. One county nurse traveled 2,106 miles during May compared with 905 miles during the previous month. Charleston County had a total of 189 cases; the total for the whole State was 448 cases.

One of the needs of major importance was a program of staff education for the public-health nurses in order to give them a knowledge of the disease, of the proper care of the patient with poliomyelitis in all stages, and of the content and importance of follow-up work. Since the four additional nurses were to stay for only 3 months, provision had to be made for as complete a program as possible in this short period. This was particularly necessary because the State orthopedic consultant nurse would have to cover the entire State after the visiting nurses had returned to their respective agencies.

A course of lectures was begun in June at the health department. In addition to the staff, the two Metropolitan Life Insurance Co. nurses, the staff at Roper Hospital, the private-duty section, and the Work Projects Administration nurses assigned to the health department were invited. The epidemiologists from the United States

Public Health Service who were assigned to study the epidemic also attended the lectures whenever possible.

The institute covered a period of 4 weeks, with 1-hour classes daily and with a written review at the end of each week. During the first week the institute was concerned with a study of poliomyelitis and a discussion of the main muscles involved. During the second week it dealt with the care of the patient with poliomyelitis in all stages of the disease. This included a demonstration of the neutral rest position, improvisation of equipment, apparatus, and discussion of contractures, their prevention and correction. During the third week the methods of applying heat, massage, and exercises were presented. A muscle examination was also demonstrated, not to teach the nurses how to administer the physical-therapy treatment, since the institute could not, of course, offer adequate instruction in this field, but to complete the picture of the care of the patient with poliomyelitis. During this week also the mental health of the patient and the importance of adequate follow-up work were stressed. The fourth week included a discussion of some of the other orthopedic conditions met by the nurses in their visiting and a brief outline of the treatment and handling of these conditions.

A patient in the convalescent stage of poliomyelitis with moderate involvement of the left upper extremity and an airplane splint applied to his arm proved to be valuable as a subject for demonstrations during the course. Much interest was shown by the nurses in the lectures, and there was a gratifying response to the institute, evidenced by the grades in the weekly written reviews. A clinic room with a blackboard and an examining table made a most satisfactory classroom.

Soon after the arrival of the nurses lent to South Carolina a schedule of visiting in the homes with the local public-health nurses was worked out, and regular visits to all children who had had poliomyelitis was begun. The nurses observed the demonstration of care to the mother, the return demonstration by her, the instructions given the mother in regard to avoidance of fatigue, prevention of deformities, application and removal of splints, and all the other fundamental points for the complete care of the patient. During these visits appointments were made for the next visit to the orthopedic clinic, and the report of the last clinic visit was discussed with the mother. After the home visits a conference was held with each nurse about the patients she had seen.

With few exceptions the mothers were found to be most interested in following to the best of their ability the instructions given them and to respond well to the teaching. The importance of following exactly the instructions of the doctor and the nurse was emphasized. The public-health nurse lent to Charleston assisted at the orthopedic clinic at Roper Hospital two afternoons each week, and this was found to present a good opportunity to continue the teaching begun in the home and to stress points needing emphasis. The social worker at Roper Hospital proved of value to the nurse as a connecting link in work with the patients.

As the children improved, casts were removed, and non-weight-bearing splints were applied. If patients could not pay for the recommended splints the apparatus was authorized and paid for by the State Crippled Children's Division. The patients who were unable to pay for their splints comprised three-fourths of all the cases in Charleston County. Only one-fourth of the patients received private care. In general the homes from which the patients came were very poor, and many of them, especially in the rural parts of the county, lacked any modern conveniences. A majority of the homes consisted of one- or two-room cabins a mile or two off the main roads on paths full of ruts and mud.

At intervals during the summer the nurse lent to Charleston visited with the orthopedic surgeon the other eight counties under his supervision and assisted him in examining new patients and applying needed casts to the patients in those counties who, for one reason or another, had not been admitted to Roper Hospital. Subsequently, these same patients began coming in to the Roper orthopedic clinic with their county nurses for examination and appliances, as their conditions warranted it. Consultations were held with the county nurses regarding their patients, and physiotherapy was demonstrated to the mothers whose children were ready for it.

The 3 months were going quickly. The epidemic was quieting down, and the problem of how best to leave the patients recovering from poliomyelitis in the charge of the staff nurses was coming to the fore. Of necessity, the patients would have to be included with many other patients and duties of the general staff and, however hard the nurses tried, the patients would not receive the concentrated, specialized care which they would need for months to come. Toward the end of August, after two of the nurses had already left, the time was extended for 1 month for the two additional nurses remaining on the State staff.

Physical-therapy treatments were begun for only a few patients at this time. The number of children on whom these treatments could be started was limited for two reasons: First, 2 months must elapse after the onset of the disease before the orthopedic surgeon in charge advised beginning physical therapy on a patient; second, the mothers of the children chosen should be intelligent and cooperative enough to follow instructions exactly as given. It was planned that these mothers would continue the physical-therapy treatments with the help of the doctor, who would change the exercises as the patient progressed.

In some cases early signs of deformity were developing, and these were discussed with the staff nurses as well as with the mothers, so that further development of the deformities would be prevented. During the last few weeks of the 4 months a final discussion was held with each nurse concerning her patients. The nurse lent to Charleston tried to present a picture of the progress of her patients and attempted to anticipate some of the conditions which might occur if they were not watched closely.

During this fourth month a plan for the children with poliomyelitis was worked out, to be used after October 1, when the nurse assigned to Charleston was scheduled to leave. It was decided to put one staff nurse in charge of all the patients. She would visit Roper Hospital on the two orthopedic-clinic days. The nurse in charge would bring back reports to the staff from the orthopedic surgeon, and she would also carry to him messages from the staff in regard to the patients. This plan would give a continuity and uniformity to the follow-up work. In this plan were also included suggestions as to the frequency of visits and the content of the visit, even though what occurred later made it unnecessary to use this plan. Its outline has been included in this paper to show the reader the provision that was made for the staff to continue with the patients without the help of the nurses who were lent.

During October it was learned that funds had been secured to enable the nurse assigned to Charleston County to remain for 6 additional months and by November money had been made available for the extension of service of both nurses for 6 months longer.[1] Physical-therapy treatments were then begun on all the patients, and the mothers were taught to carry on with the treatments between the nurse's visits.

Some of the problems which were present could now be taken up much more fully, since there was more time to work them out. One of the major difficulties was transportation to the clinic. About 30 children in outlying parts of Charleston County had no way of getting to the clinic unless some one brought them. At this time one of the local college groups, consisting of wives of the professors, offered to help the Crippled Children's Society, and a volunteer motor corps was organized, which has been functioning smoothly ever since. This group furnishes cars, drivers, and gas, and the Crippled Children's Society pays them at the rate of 2 cents a mile. They transport an average of six children to the clinic each week. During the summer vacation this work was taken over by the Rotary Club auxiliary.

A foster home for underprivileged Negro children was established in October. The children chosen for this home had severe and extensive paralysis. At the present time a colored mother outstanding in intelligence is caring for five patients. She has been taught the treatments for each child, including baking, massage, and exercise, and the children are responding well to her care.

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[1] Funds have since been made available to provide for extension of the service of these two nurses through the fiscal year ending June 30, 1941.

The Charleston nurse receives patients and their parents in her office 2 days a week for consultation and treatment. In this way she takes care of as many children as possible in a given place, thereby easing the home-visiting load. About 21 or 22 children come from the city and the county each week.

The problem of education for children who have had poliomyelitis at present has not been solved. In the winter of 1939 a child-welfare council was organized in Charleston by the Junior League, and the subject of education was brought up. This had previously been discussed with the Crippled Children's Society. It is hoped to have a visiting-teacher service organized, beginning perhaps on a small scale and enlarging gradually to include service for all the crippled children who need it.

There is also the problem of occupational therapy and, for those needing it, vocational rehabilitation when they are ready.

A local church group assisted in supplying toys and additional milk and extra food. Some of the other church groups have cooperated at various times during the year. At Christmas one group gave a pageant to which all the patients were invited. Another group gave 40 Easter baskets for some of the underprivileged children. The latter group has functioned in taking reading material to some of the older patients regularly. A third group has given needed physiotherapy equipment. Cocoa butter and talcum powder are furnished by the Crippled Children's Society for use in massaging the patients. This society also made arrangements for two of the children with the most severe involvements to be admitted to Warm Springs, Ga., and for one to go to Shriners' Hospital in Greenville, S. C.

Staff education has continued with a second series of lectures in the spring of 1940 on orthopedic conditions. This group of lectures was integrated into a program of staff education for the entire health department. The first lecture was concerned with the active list of patients with poliomyelitis, and the progress of the patients to date was discussed with the nurses.

This lecture covered the importance of becoming more conscious of orthopedic conditions and awake to all the orthopedic problems which are present and need attention.

Staff visiting with the nurse assigned especially for orthopedic care has continued, including visits not only to the patients with poliomyelitis but to patients with other orthopedic conditions, who are known to the nurses. When the orthopedic surgeon in charge of the area sees those patients he finds that in almost every instance some constructive work can be instituted to improve or completely correct the patient's condition. Conferences with the nurses are a regular part of the program, and an increasing awareness of orthopedic problems by the staff is noted.

The local public-health nurses usually are present at the conferences which the nurse assigned for orthopedic care holds in her office and are able to observe the progress of the patients. Four children with cerebral palsy are now included in these conferences for white children, and they are all seen at the same time. This has proved beneficial for the children, and the mothers are glad to have definite instruction for improving the muscular coordination and general well-being of their children. The Crippled Children's Society contributed three books on cerebral palsy to the health department library. These books are lent to the mothers, who find them of great value in giving them a better understanding of their problems. A posture clinic is to be started soon for those children with poor posture discovered in the summer preschool round-up, which the health department holds in cooperation with the parent-teacher association.

Lectures are given by the orthopedic consultant nurse at intervals to groups ranging from a parent-teacher association meeting on poliomyelitis to a group of midwives discussing what orthopedic conditions to look for in newborn infants. Lectures have been given on orthopedic subjects to the student nurses and the graduate nursing staff at Roper Hospital. Discussion has followed with individual nurses interested in certain phases of the work presented.

Thus the 92 children who contracted poliomyelitis during the epidemic and are still on the active file are receiving constant care based on the close coordination of the patient, the parents, the doctor, and the public-health nurses. The community is working with them, and through the joint efforts of all a well-rounded program is functioning. The needs of the children still to be met have been reviewed, and steps are being taken to fulfill these needs. The orthopedic consultant nurse takes on other orthopedic patients as her case load permits. A broader interpretation of the term "crippled child" to include all handicapped children is being incorporated in the work of the staff with an increasing number of orthopedic patients being given attention.

The matter of further extension of the special services of the consultant nurse in Charleston beyond the present 6 months is being contemplated. The work described has been made possible by the cooperation of local, State, and Federal agencies, and the National Foundation for Infantile Paralysis, working together for the betterment of the crippled child.

Social-Security Plans Approved for Puerto Rico

In July 1940, slightly more than 6 months after Puerto Rico became eligible for Federal grants for social-security services for children under the 1939 amendments to the Social Security Act, the Chief of the Children's Bureau approved plans submitted by Puerto Rico for services for crippled children and for child-welfare services for the fiscal year 1941. A plan for maternal and child-health services had been in operation since February 1940. For 2 months of the fiscal year 1940, also, there had been a plan for child-welfare services in operation.

• CHILD WELFARE • • SOCIAL SERVICES • • CHILD GUIDANCE •

Child-Welfare Services for Rural Children in Hawaii

By Margaret Bevis

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In 1937, stimulated by the Federal Social Security Act, the Territorial Legislature of Hawaii incorporated in the Public Welfare Act a number of sections which had to do with the welfare of children. Section 30 made it possible for the Territory to receive Federal funds to pay the salaries and part of the administrative expenses of children's workers in predominantly rural and other areas of special need.

The Social Worker Is a "Malihini."

In any new area the worker's first problem is to learn to fit the services she has to offer in with the community ways. The more rural the area the closer the community seems to press around the individual. In working out a children's case the attitudes and opinions of the school teacher, the judge, the minister, the policeman, the camp boss, and the neighbors must be taken into account as definitely as the attitudes and opinions of the members of the family. Sometimes, especially when the worker is a *malihini*,[1] the referring agents have already decided what should be done about the case and have no intention of letting the client and the worker get together on any other basis.

In the country it is difficult to establish and maintain a confidential relationship, especially with a person who is considered a community problem. Everyone already knows all about him—much more than a *malihini* social worker could possibly know. If the worker does not speak the language of the home, an interpreter may have to be called in. Many households are always full of friends, relatives, and neighbors. The very fact that the worker wants to talk with an individual alone may arouse more interest, curiosity, and harmful misinterpretation than would discussing the child's or family's difficulties in open forum. Talking with anyone alone is even more difficult in crowded plantation camps where the neighborhood children and adults come in to the house uninvited or stand on the porch and look and listen through the windows.

It seems to me the worker's only course is to be very frank and open in her dealings with the community. In most instances it seems wise to take time to explain to anyone who is legitimately interested what is being done and why. This is one way for the community to come to some understanding of what the agency has to offer. Also it is better for the client if the people he lives with have a true and sympathetic version of his situation and relation with the agency than if they have a garbled and often grossly false one. In the country the worker's errors of judgment affect not only the client involved but the agency's relationships in that community, perhaps for years to come; and in protective work we cannot go farther than the community will let us go.

In a certain district in Hawaii a woman in her late 70's is living with her six *moopunas*[2] ranging in age from an infant to a girl in her teens. The old woman wanders around the shack in rags, her face unwashed, her hair uncombed, mumbling to herself. The little children are dirty, half-starved, and covered with sores. The older children wander about in search of food and excitement. Their absence for a night or even a week does not disturb the grandmother.

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[1] *Malihina:* a stranger; a newcomer.

[2] *Moopuna:* grandchild.

Last year a small child in this family died, apparently from exposure, lack of medical care, and lack of food. The public-health nurse reports going to the house and finding another child lying on the floor on a pile of rags. The child had been badly burned. The burns had not been dressed and were covered with flies. The judge in the district admits that the situation is not "very good," but refuses to take any action because it would "kill the grandmother" if any other plan were made for the children.

On the other hand, a community can force an agency to assume the responsibility for a situation which, because of limitation of funds, personnel, or community resources, it is not prepared to meet.

Last year a family with nine children was referred to us because the parents were habitually drunk and the children were very much neglected. Since six or eight other families in the same district had been referred for similar home conditions it was decided that the problems of that section were too great for child-welfare services to handle at that time with the placement facilities available. The case was closed after efforts to work with the children in their own home proved futile as the parents were usually away or too drunk to talk. A few months later the school principal made a home visit as one of the little boys had been absent for several days. She found him lying on the bed, feverish and delirious, his arm badly swollen. The other children said that he had been bitten by a rat 3 days before. The parents were attending a party which had been going on for several days on the next street.

The public-health nurse and the principal succeeded in getting the mother sobered up enough to give permission for the child to be taken to the hospital. Through the school department the situation was referred to the court. The mother, when approached by the probation officer, was very indignant and said she was not to blame, she did not "tell the rat to bite Johnny." On the basis of the incapacity of the parents, the judge made all nine children wards of the court and asked child-welfare services to place them immediately. This is an example of the difficulties in limiting intake in the interest of doing adequate work with the children under care.

The Cultural vs. the Geographic Community.

In Hawaii it seems difficult to determine just what the community is. Two kinds of things here determine "community"—cultural or racial background and geography. We may have several racial and cultural communities in one geographical section and extending beyond it, and yet geographical communities are very real entities too. There is a cohesiveness among people living in Kona or Kohala or Hilo regardless of racial background.

Methods used by cultural communities to meet children's needs are usually extralegal and may be deeply intrenched in the group. They are unconsciously aimed toward the preservation of the culture of the group, and their use is continued because they are so much a part of the cultural heritage that they seem right and "natural" to those brought up in that culture. If any pressure is needed for their continuance it comes from the leaders and older members of the group itself.

In contrast the geographical community includes the judge, the police, the schools, the board of health, the community chest and various social agencies supported by it, churches and religious groups with social aims, service clubs, plantation managers and personnel directors, plantation doctors, agricultural extension agents, and, in fact, a large and heterogeneous group of public officials and private organizations and individuals whose function and interest touches on social betterment.

If children's problems are not met by their own families or cultural group this group is likely to attempt to meet them. The methods used often tend to separate the child from his own cultural group. Because such methods are usually not understood intellectually or accepted emotionally by those nearest to the child the use of authority tends to take a prominent place. This authority is sometimes derived from law and sometimes from the economic or social position of the person interested in working out a plan. However, persuasion and educational methods have also been used with varying degrees of success.

The methods used by the two types of communities in dealing with the child deprived of parental support—a very common problem in Hawaii—are interesting to compare. For a number of reasons, such as susceptibility to disease, the breaking down of old moral sanctions in immigrant groups, and the presence of groups of transient men, a large number of marital unions in Hawaii are of much shorter duration than the time required to rear a family. It is also interesting to speculate to what extent incoming groups have been influenced by the primitive Hawaiian family structure in which the rearing of all children by their biological parents is not necessarily the social norm or ideal.

The "Hanai,"[3] or Foster Child.

Care by relatives or foster-home placement in the homes of unrelated families is the usual method of the cultural communities of caring for children away from their own families. I am sure there is no other place in the United States, or perhaps in the world, where so large a proportion of the population have at some time in their lives been foster parents, foster children, or both. There is, of course, some variation from group to group in the kind of placements made.

Japanese families, for instance, usually make every effort to care for the legitimate children of relatives if anything happens to the parents. If there are no relatives, people from the same district in Japan often assume responsibility.

Hawaiians, on the other hand, often place children with unrelated families. In this group placement does not necessarily mean that the child's own family has broken down or is unable to care for him, for the giving and receiving of children as *hanais* is a well-established Hawaiian custom. It is not unusual to find families who have given one or more of their own children as *hanais* and who are caring for children given to them by other families. *Hanais* are usually accepted by their foster parents at birth or in early infancy, but most Hawaiian families freely take in other children or adults who seem to need a home.

Usually, but not always, foster parents belong to the same cultural group as the child's own parents. Hawaiian families freely accept children from other groups and in some cases seem to prefer Oriental children to Hawaiian children. Japanese babies born out of wedlock, whose relatives are anxious to conceal their existence, are often given to Hawaiian families.

Placements are made by parents, friends, relatives, community leaders, and even by the children themselves.

> A little girl, whose mother was dead, went to play with some puppies at a house she passed on the way to school. The family noticed that the child was dirty and ill-kempt. When she expressed a desire to stay with them the man of the house went to her father and secured his permission for the child to remain. A little boy often went to the home of a fairly well-to-do Hawaiian woman to ask for food. She felt sorry for him and asked his mother if she could keep him. The mother said, "If you want him, take him."

In some cultural groups there is a strong attitude that children in need of a home should be cared for by relatives. Children are often taken to avoid community criticism even when the family does not want them and is ill-prepared to care for them.

The child's economic status is not necessarily improved by placement as the foster parents are usually on about the same economic level as the real parents. When several children are taken into an already overcrowded household, the inadequate income has to be stretched just that much thinner.

On the other hand, children are often taken more for the benefit of the foster parents than for the welfare of the children. Children are sometimes taken for the help they can give.

> In an isolated district a family consists of an elderly couple and two little girls taken as *hanais*. The woman is almost blind, and the man is partially paralyzed and practically bedridden. The little girls do all the housework and provide whatever nursing care the old people receive. The children did not even start to school until they were 8 or 9 years of age because the old people needed them at home.

Very old persons are often found caring for small children and even infants. It is frequently impossible to do anything about these situations even when the children are much neglected because the relatives and the community at large consider the rights and desires of the old person more important than the welfare of the child. A single man or a group of single men will sometimes take a child or two to care for. They are usually lonesome and belong to groups which have little opportunity to marry and have families of their own.

I have discussed this type of child care in considerable detail, because at our present level of development in Hawaii most children's problems are worked out in some such way. Care arranged by the child's own cultural community sometimes provides security, understanding, and an adequate meeting of the child's most fundamental needs, but sometimes it does not.

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[3] *Hanai:* a child given by his mother to another person.

Child-Welfare Methods of the Geographical Community.

The geographical community was taking a very active part in child welfare before child-welfare services were set up on the island constituting Hawaii County, one of the four counties of the Territory of Hawaii. A boys' home founded in 1906 and a girls' home in 1926 cared for approximately 100 dependent and delinquent children. Both homes were and are still controlled by church groups outside the community but financial support was local, coming largely from the county and community chest. Both homes accepted children with little investigation of their needs. Children presenting behavior problems which their parents seemed unable to cope with were often accepted. If children proved too unmanageable they were usually sent back to their parents, relatives, or anyone who would take them, often without investigation or follow-up. The institutions had a good deal of community backing, and on the whole they provided better and more responsible care for the children they accepted than many of the foster homes of that period.

Although foster-home placement was not organized, many agencies and individuals were placing children in private families. The old board of child welfare of Hawaii County, which in 1937 was absorbed by the county commission of public welfare, placed children in free and wage homes and even in a few instances made county grants for the care of children in foster homes. Prior to 1937,[4] the two circuit judges acting as juvenile judges could commit dependent children to the care of reputable citizens. District magistrates (who have concurrent jurisdiction in juvenile matters) also placed children. Placements were often made by paid and volunteer probation officers, policemen, school principals, teachers, board of health and plantation nurses, and others who found children in need.

In selecting a foster home these official or semiofficial persons often were influenced by their own cultural background, which in many instances differed from the child's. Children were more likely to be placed in families differing from their own racial ancestry, economic status, standard of living, and educational background. If the child was placed in his own ethnic group subtle distinctions important to the group itself but unknown or without significance to outsiders were likely to be ignored.

I do not know how much study of the children and of the foster homes preceded these placements. In most instances there are no records, and the records which do exist are meager. Sometimes undoubtedly the person making the placement knew both the child and the foster home well. In other cases placements were made on the basis of superficial observation. There was often little, if any, follow-up. Older children were usually taken, at least in part, for the work they could do. In most instances there seemed to be more interest in punishing the family for unacceptable behavior by taking their children away than concern over what was to become of the children.

A little girl was beaten by her aunt and uncle with whom she was living. The court took her away and gave her to another family who had a nice house and a fairly good income. The child was taken out of school when she finished the fourth grade and was expected to help with the housework. She often kept the house and cared for the younger children while her foster mother visited friends and relatives on other islands or took part in social activities. The child again came to the attention of the court when she was 13 and had become pregnant by her foster father.

Changes Since the Establishment of Child-Welfare Services.

The greatest change made by child-welfare services has been the development of a group of boarding homes. When the first children's worker arrived at the Island of Hawaii in September 1937 the public welfare commission was using two boarding homes. Both boarding mothers were elderly widows with meager incomes, living in poor surroundings. Neither of them spoke much English, and their methods of child care were far from modern. At present 65 children are being cared for in 34 boarding homes, with standards that do not compare too unfavorably with those of homes accepted by good agencies elsewhere.

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[4] In 1937 the legislature provided for the commitment of dependent children to the Territorial Board of Public Welfare or to the county commissions of public welfare [duties transferred to new Territorial Department of Social Security in 1939].

At first there was a good deal of opposition to boarding care. The belief that families who accepted board were entirely mercenary was widespread. Many people thought that if money was to be spent it would be better to build larger institutions so that they would "have the children all under one roof" and where they could be "looked after better." Most people thought that $15 a month was a great deal of money to spend on the care of one little child and were very much surprised to learn that care for a child in one of the institutions averaged $27. Gradually, as individuals have come in contact with boarding parents and boarding children and observed that the children receive good care, they have become more favorably disposed.

We have had little success in finding free foster homes, perhaps because anyone who wants to care for a child free has many opportunities to do so without coming to a social agency. Free and work homes used are investigated before placement and are supervised while the child is in the home.

The number of children in institutional care has declined to 59. One institution requested that its population be limited to prevent overcrowding and to insure better care for the children accepted. The decline in the population of the other institution is due largely to frequent changes of policy and management that resulted in closing the home entirely for several months at one time. All applications for admission are referred to the children's worker, and plans are made for all children at the time of discharge.

The institutions now are supported largely by the community chest and the Department of Social Security, $27 being paid for each child placed. The county funds are now used by the juvenile court for the care of delinquents. Delinquents are not placed in the institutions unless it is believed that they will fit in with the group of dependent children under care.

One circuit court cooperates very closely with the Department of Social Security not only in committing dependents to the care and custody of the director but in referring all adoption and guardianship cases for investigation.[5] The other circuit court has changed its practices very little since 1937.

A number of services have been made available to children since 1937; those of a county dentist, the traveling mental-hygiene clinic, and more adequate services from the psychological clinic. The government medical set-up does not provide adequate medical care for children in most localities, but this need is being met at present through services volunteered by physicians.

The County of Hawaii is an island which covers 4,015 square miles and has a population of approximately 82,000, made up of many widely different ethnic groups; as might be expected, the degree of understanding, acceptance, and support of a child-welfare program varies greatly from locality to locality and from group to group.

There is no doubt that we have been more successful in grafting child-welfare services on to the methods used by the geographical community than to the ways of the various cultural communities. The fact that most of the applications for services come from teachers, nurses, and probation officers and others who want something done about other people's children rather than from parents who want help with their own children's problems shows this only too clearly. This is in some ways unfortunate, for a service which is understandable and acceptable to the groups most in need of it would be in a better position to help than one which leans too heavily on authority. By means of better case work and more adequate community interpretation, especially if we can secure well-trained workers belonging to and oriented in the cultures of the major community groups, we may eventually be able to work out this problem. Also, as assimilation progresses the cultural communities will move closer together.

To date the part of the community which knows the children in need, including teachers, probation officers, and nurses, is demanding more extensive services from us than the part of the community which holds the purse strings, i. e., the legislature and heavy taxpayers controlling the legislature, has made it possible for us to render. Our present case load of 204 children is much too large for two workers to care for adequately. At present a citizens' committee on child-welfare services is making a survey of the dependent children, homeless and neglected children, and children who are in danger of becoming delinquent for whom the community is doing nothing. So far, 160 children have been reported whose needs seem as urgent as those of the children in care. In this way at least a small part of the community is beginning to face with the workers some of the destructive experiences which are happening to children and which only the community itself can provide the means to prevent.

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[5] The 1939 legislature made it possible for judges to request investigations in adoption cases if they wish to do so.

Child Welfare Under the New Constitution of Cuba[1]

By Anna Kalet Smith

Associate in Foreign Research, U. S. Children's Bureau

The new Constitution of Cuba, adopted in June 1940 by a convention of specially elected delegates of the people, reveals recent social trends in Latin America indicating concern for the welfare of the child, the mother, the worker, and for general social betterment. For the first time in Cuban history is an extensive program of family welfare, public education, and protection of labor found in the Constitution; and the enactment of the program into law is made mandatory.

The first Constitution of the Republic of Cuba was adopted in 1901 and amended in 1928; it was replaced in 1935 by the "constitutional statutes," which were intended to meet the emergency problems of the Provisional Government after the overthrow of President Machado. These statutes will remain in force until the new Constitution goes into effect, October 10, 1940.

Under the new Constitution the family, motherhood, and marriage are placed under the protection of the State. Marriage is accepted as the legal foundation of the family; husband and wife are given equal rights. The fees for marriage are abolished. The married woman receives full civil rights and no longer needs her husband's permission to manage her property, to engage in paid work, and to dispose of the products of her work. A law is to be enacted for the liberalization of divorce procedure.

Parental responsibilities under the law have been increased. Parents are required to support, educate, and properly train their children—both children of legitimate birth and children born out of wedlock if at the time of conception the parents were legally capable of contracting marriage. Laws are to be enacted to assure the fulfillment of these duties.

In its approach to the problem of illegitimacy the Constitution orders the enactment of a law permitting investigation of paternity. It prohibits reference to illegitimacy on birth certificates and other documents in accordance with recommendations of the Child Welfare Committee, predecessor of the present Advisory Committee on Social Questions of the League of Nations.

The need for protecting children and young people against exploitation and physical and moral neglect is also recognized; the State, the Provinces, and the municipalities must establish adequate facilities to this end.

The principle of compulsory school attendance, set forth in the Constitution of 1901 and later supported by law, has its place in the present Constitution also; but now the duty to provide primary education is placed on the State, without regard to municipal initiative. Kindergarten, primary, and vocational education is to be given free of charge in public schools.

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[1] Based on original Cuban sources.

Schools are to be opened in rural communities. Measures for the elimination of adult illiteracy and for the solution of various other educational problems are also prescribed.

Standards of progressive labor legislation, closely following those developed by the International Labor Organization, are presented at length, and their enactment into law is made mandatory.

Also closely affecting mothers and children is the provision for a general system of social insurance—although maternity insurance has been effective in Cuba since 1937—for the legislative protection of working mothers, both in manual and nonmanual occupations, and for the prevention of discrimination against married women in industry. A rest of 6 weeks before confinement and 6 weeks afterward with full pay is to be given to every woman by law; her employment and all her rights in connection with her employment must be reserved for her. Two periods of one-half hour each, in addition to the regular rest periods, must be allowed daily to every nursing mother to enable her to nurse the child. The maximum hours of work are limited to 8 a day and may be reduced by law to 6 hours for children between 14 and 18 years of age. A minimum age of 14 is prescribed for employment. A month's vacation with pay is to be given for every 11 months of work.

Most of the standards for safeguarding mothers and children have been enacted by law in Cuba since 1934. They are now given permanence by their incorporation in the Constitution.

Provision of adequate housing, schools, hospitals, and other facilities for the physical and moral welfare of the workers and their families will be made compulsory by law for industrial establishments in rural localities. Projects for low-cost housing are to be aided by the State.

The employer is to be held responsible for compliance with the labor laws, even when he engages his workers through an intermediary. The State is required to appoint inspectors for the enforcement of the laws in business establishments.

In its consideration of prevention and treatment of delinquency the Constitution directs the establishment of juvenile courts, demands for which have been frequent in recent years.

A system of social aid with hospitals and other necessary institutions is to be organized by law under the Ministry of Health and Social Welfare and provided with funds from the National Treasury; the services of hospitals and other public institutions must be free to the poor.

In conclusion the Constitution directs the enactment of the prescribed legislation within three legislative periods.

BOOK NOTES

CIVIL SERVICE IN PUBLIC WELFARE, by Alice Campbell Klein. Russell Sage Foundation, New York, 1940. 444 pp. $2.25.

The publication of this book is especially timely in view of the fact that many public agencies are establishing merit systems and that civil-service agencies are expanding their facilities to meet the requirements of the amendment to the Social Security Act passed on August 10, 1939, relating to the establishment and maintenance of personnel standards on a merit basis.

Part One—Civil Service: Its Functions and Procedures—is characterized in the introduction as a "primer" of civil-service history and practice.

Part Two—Where Social Work and Merit Systems Meet—discusses problems and issues raised in the application of civil-service rules and methods to the public-welfare field. The author states:

> The important tasks on the social-work horizon of today, so far as public welfare is concerned, are to understand the nature of personnel needs in public welfare, to work out standards of training and selection that will facilitate the employment of personnel qualified to meet those needs, and to help civil-service agencies translate those standards into criteria of measurement. Public-welfare administration is part of the total government program of public service. If social work is to make a contribution toward improving the practice of personnel administration in public welfare, it must ally itself, both in spirit and in action, with the large body of citizens who are interested in improving the quality of the total public service, and must understand what methods are most effectively used toward this end.

Mrs. Klein concludes with recommendations for concerted effort by the many groups of agencies concerned with the problem and for critical scrutiny of the relationships of public welfare and civil service.

B. H.

• EVENTS OF CURRENT INTEREST •

Advisory Committees

Appointed by the Secretary of Labor to Advise the Children's Bureau Concerning the Development of General Policies Affecting the Administration of Title V, Parts 1, 2, and 3, of the Social Security Act

General Advisory Committee on Maternal and Child-Welfare Services

(Members appointed April 1940 for a 3-year term)

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Fred L. Adair, M. D., professor of obstetrics and gynecology, University of Chicago, Chicago, Ill.; chairman, American Committee on Maternal Welfare.

David C. Adie, commissioner, State Department of Social Welfare, Albany, N. Y.; chairman, National Council of State Public-Assistance and Welfare Administrators.

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Dorothy Deming, R. N., general director, National Organization for Public Health Nursing, New York, N. Y.

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Mary M. Maxwell, executive secretary, American Association of Medical Social Workers, Chicago, Ill.

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Mrs. Nathan Straus, National Council of Jewish Women, New York, N. Y.

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Joe N. Hamilton, executive secretary, Oklahoma Commission for Crippled Children, Oklahoma City, Okla.

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W. C. Williams, M. D., commissioner of public health, State Department of Public Health, Nashville, Tenn.

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(For names of members of this subcommittee, which serves both the Advisory Committee on Maternal and Child-Health Services and the Advisory Committee on Services for Crippled Children, see pp. 56–57.)

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Norris E. Class, director, Child-Welfare Services, State Public Welfare Commission, Portland, Oreg.

Loula Dunn, commissioner, State Department of Public Welfare, Montgomery, Ala.

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Persis S. Holden, general secretary, Vermont Children's Aid Society, Burlington, Vt.

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Joseph B. Johnston, superintendent, Presbyterian Orphans' Home of the Synod of North Carolina, Barium Springs, N. C.

Cheney C. Jones, superintendent, New England Home for Little Wanderers, Boston, Mass.

Mrs. Lillian McDermott, referee of juvenile court, Pulaski County, Little Rock, Ark.

Lowry Nelson, professor of sociology, Department of Agriculture, University of Minnesota, St. Paul, Minn.

Right Rev. Msgr. Thomas J. O'Dwyer, general director, Catholic Welfare Bureau of the Archidiocese of Los Angeles, Los Angeles, Calif.

George H. Preston, M. D., commissioner, State Board of Mental Hygiene, Baltimore, Md.

Mrs. Sallie R. Springmeyer, member, State Board of Health, Reno, Nev.

Eileen Ward, instructor in social work and supervisor of field work in child welfare, School of Social Service, St. Louis University, St. Louis, Mo.

Special Advisory Committee on Training and Personnel for Child-Welfare Services (Children's Bureau) and for the Public-Assistance Program (Social Security Board)

(Members appointed July 1940 by the Secretary of Labor and the Social Security Board for a 2-year term)

Chairman, Edith Abbott, dean, School of Social Service Administration, University of Chicago, Chicago, Ill.

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Elizabeth Wisner, dean, School of Social Work, Tulane University of Louisiana, New Orleans, La.

Walter West, executive secretary, American Association of Social Workers, New York, N. Y.

Ernest F. Witte, director, Graduate School of Social Work, University of Washington, Seattle, Wash.

CONFERENCE CALENDAR

Sept. 9–11	International Association of Governmental Labor Officials. New York.
Sept. 16–20	American Hospital Association. Boston, Mass.
Sept. 22	National Child Welfare Conference. American Legion, Boston, Mass. Information: National Child Welfare Division, American Legion, 777 North Meridian Street, Indianapolis, Ind.
Sept. 23–29	Better Parenthood Week. Sponsored by *Parents' Magazine.* Information and program material from Better Parenthood Week Committee, 52 Vanderbilt Avenue, New York.
Sept. 24–28	National Federation of Settlements. Twenty-eighth conference, Pocono Summit, Pa. Permanent headquarters: 147 Avenue B, New York.
Sept. 30–Oct. 4	National Recreation Congress. Twenty-fifth annual congress, Cleveland, Ohio. Permanent headquarters: 315 Fourth Avenue, New York.
Oct. 5–10	National Society for Crippled Children. Annual convention, Asheville, N. C. Permanent headquarters: Elyria, Ohio.
Oct. 7–11	National Safety Council. Chicago. Permanent headquarters: 20 North Wacker Drive, Chicago.
Oct. 8–11	American Public Health Association. Sixty-ninth annual meeting, Detroit. Permanent headquarters: 50 West Fiftieth Street, New York.
Oct. 21–24	American Dietetic Association. Twenty-third annual meeting, New York.
Nov. 10–16	American Education Week. Twentieth anniversary. Information and program material from National Education Association, 1201 Sixteenth Street NW., Washington, D. C.
Nov. 12–15	Southern Medical Association. Thirty-fourth annual meeting, Louisville, Ky. Permanent headquarters: Empire Building, Birmingham, Ala.

U. S. GOVERNMENT PRINTING OFFICE: 1940

UNITED STATES DEPARTMENT OF LABOR

Frances Perkins, Secretary

◆

CHILDREN'S BUREAU

Katharine F. Lenroot, Chief

THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives THE CHILD.

THE CHILD is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to the editor, THE CHILD, Children's Bureau, United States Department of Labor, Washington, D. C.

THE CHILD is for sale by the Superintendent of Documents, Washington, D. C., at $1 a year; foreign postage, $0.50 additional. Single copies are 10 cents each. Subscription orders should be addressed to the Superintendent of Documents, Government Printing Office, Washington, D. C.

The CHILD
Monthly Bulletin

TRIP RIDER IN A HAULAGEWAY OF A COAL MINE

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

SEPTEMBER 1

U. S. SUPERINTENDENT OF DOCUMENTS
OCT 11 1940

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Volume 5. Number 3 September 1940

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The Children's Bureau does not necessarily endorse or assume responsibility for the statements or opinions of contributors not connected with the Bureau.

Lillian D. Wald

By Katharine F. Lenroot

Chief, United States Children's Bureau

ON the first of September Lillian D. Wald, one of the greatest friends of children this Nation has ever known, joined the choir invisible of those whose influence and inspiration will be forever a part of the Children's Bureau. Jane Addams, Florence Kelley, Julia Lathrop, Grace Abbott, Lillian Wald—these were set apart as a unique group by their outlook upon life, their strong and fearless intellects, their sensitive and compassionate awareness of human need, their practical grasp of public affairs, their ability to translate aspirations into reality. Of their understanding and their capacity for leadership the Children's Bureau was born and by them it was nurtured.

To Lillian Wald particularly does the Children's Bureau owe its existence, for it was she who first conceived the idea of a Federal bureau dedicated to the interest of all children. Tirelessly throughout 6 years she and those associated with her strove for the establishment of the Bureau. They had the help of some of the Nation's greatest statesmen, including President Theodore Roosevelt. But Lillian Wald did not rest content when the new Bureau was launched or even after it had become well established in the national life. Her interest in its activities, her concern for its future, her sympathetic understanding of the problems of those responsible for its administration never flagged. Even after she was stricken by severe illness she kept up correspondence with those who were concerned that the Bureau be strengthened in proportion to the increasing demands upon it and the ever-growing public conception of the Nation's obligations toward its children.

As Chief of the Children's Bureau, Grace Abbott frequently visited Lillian Wald in Henry Street or in her Connecticut home, and after she became seriously ill it was my own great privilege to have a visit with her. She was honored at the dinner celebrating the twenty-fifth anniversary of the Children's Bureau, April 8, 1937, and tribute was paid to her at meetings of the White House Conference on Children in a Democracy. It is fitting that her own story of the establishment of the Children's Bureau and what it meant to her should be repeated here:

> Experience in Henry Street, and a conviction that intelligent interest in the welfare of children was becoming universal, gradually focused my mind on the necessity for a Federal Children's Bureau. Every day brought to the settlement, by mail and personal call—as it must have brought to other people and agencies known to be interested in children—the most varied inquiries, appeals for help and guidance, reflecting every social aspect of the question. One well-known judge of a children's court was obliged to employ a clerical staff at his own expense to reply to such inquiries. Those that came to us we answered as best we might out of our own experience or from fragmentary and incomplete data. Even the available information on this important subject was nowhere assembled in complete and practical form. The birth rate, preventable blindness, congenital and preventable disease, infant mortality, physical degeneracy, orphanage, desertion, juvenile delinquency, dangerous occupations and accidents, crimes against children, are questions of enormous national importance concerning some of which reliable information was wholly lacking.
>
> Toward the close of President Roosevelt's administration a colleague and I called upon him to present my plea for the creation of this bureau. On that day the Secretary of Agriculture had gone South to ascertain what danger to the community lurked in the appearance of the boll weevil. This gave point to our

argument that nothing that might have happened to the children of the Nation could have called forth governmental inquiry.

The Federal Children's Bureau was conceived in the interest of all children; but it was fitting that the national committee on which I serve, dedicated to working children, should have become sponsor for the necessary propaganda for its creation.

It soon became evident that the suggestion was timely. Sympathy and support came from every part of the country, from Maine to California, and from every section of society. The national sense of humor was aroused by the grim fact that whereas the Federal Government concerned itself with the conservation of material wealth, mines and forests, hogs and lobsters, and had long since established bureaus to supply information concerning them, citizens who desired instruction and guidance for the conservation and protection of the children of the Nation had no responsible governmental body to which to appeal.

Though the suggestion was approved by President Roosevelt and widely supported by press and people, it was not until the close of President Taft's administration that the Federal Children's Bureau became a fact, and the child with all its needs was brought into the sphere of Federal care and solicitude. The appointment of Miss Julia Lathrop, a woman of conspicuous personal fitness and adequate training, to be its first chief was a guarantee of the auspicious beginning of its work. In the brief time of its service it has had continuous evidence that the people of these United States intelligently avail themselves of the opportunity for acquiring better understanding of the great responsibility that is placed upon each generation.

The Federal Children's Bureau would not fulfill the purpose of its originators if its service were limited to the study and record of the pathological conditions surrounding children. Its greatest work for the Nation should be, and doubtless will be, to create standards for the States and municipalities which may turn to it for expert advice and guidance. With the living issues involved it is not likely to become mechanical.

The Children's Bureau is a symbol of the most hopeful aspect of America. Founded in love for children and confidence in the future, its existence is enormously significant. The first time I visited Washington after the establishment of the Bureau I felt a thrill of the new and the hopeful, and I contrasted its bare office with the splendid monuments that had been erected and dedicated to the past. Some day, I thought, a lover of his country, understanding that the children of today are our future, will build a temple to them in the seat of the Federal Government. This building will be more beautiful than those inspired by the Army and Navy, by the exploits of science or commemoration of the dead. As my imagination soared I fairly visualized the Children's Bureau developed, expanded, drawing from all corners of the land eager parents and teachers to learn not only the theory of child culture, but to see demonstrations of the best methods in playgrounds, clinics, classes, clubs, buildings, and equipment. The vision became associated with a memory of the first time I saw the Lucca della Robbias on the outer wall of the Florentine asylum and felt the inspiration of linking a great artist with a little waif. But those lovely sculptured babes are swathed. Some day, when the beautiful building of the Federal Children's Bureau is pointed out in Washington, I have it in my heart to believe that the genius who decorates in paint or plastic art will convey the new conception of the child—free of motion, uplooking, the ward of the Nation.—From *The House on Henry Street, by Lillian D. Wald.*

An editorial tribute from the *New York Times*, September 3, 1940, follows:

MISS WALD OF HENRY STREET

Lillian D. Wald was the founder and for 40 years the beloved head of the Henry Street Settlement. She organized the first widespread nonsectarian visiting nurse service in the world, and lived to see the visiting nurse following in her footsteps, in every American State and city, in almost every country on earth. The school nurse, the ungraded classes for handicapped children, the Children's Bureau came out of the warm, intelligent sympathy which she set glowing on Henry Street. She fought the evils of the sweatshop, of underpaid and overworked labor, of fire hazards in houses and factories, of bad housing, of inadequate play space. She fought against war and against racial and religious intolerance in all of its forms. The brotherhood of man was no fine phrase for her: it was her whole life.

Her career grew out of a simple, unostentatious act. She went to the East Side, with one companion, to do what she could with her own hands to lessen the burdens of the sick poor—and a new humanitarian agency grew out of the adventure. She invited her new neighbors to visit her East Side home—and discovered that she had established a social settlement. She made no distinction between the humble and the famous, the rich and the poor. She loved and respected the scrubwomen, the penniless immigrants, the jobless fathers of families, the sick, the sinful, the desperate who came to her door; but there came also, in all humility, the renowned, gifted, and successful of all lands. With the same joyous grace she welcomed a street cleaner and a prime minister, a fish peddler, and a governor or president.

She was a reformer, but never one of rueful countenance. Her pity was easily aroused, her indignation could burn hotly against injustice and oppression, yet wherever she went she carried the healing power of generous laughter. Humanity was for her a lifelong adventure. She read it as eagerly as a scholar reads his books. A friend said of her that she was never consciously tolerant, because she never admitted that the infinite differences in human nature called for tolerance. To her they were endlessly fascinating, endlessly appealing. In the unspoiled humanness of children she took lifelong delight. She respected childhood in a wholly unsentimental way, and to children she seemed not a teacher nor a critic but a friend. Friendship, extended without self-consciousness or self-righteousness, was in her a supreme quality. As a result, her friends literally cannot now be counted. They are in every land, of every race, of every creed.

There may never be another social settlement which will be precisely what Henry Street was under Lillian Wald. Much that settlements once did has been taken over by public agencies. Nursing, too, may move into the public field. But the great lesson of democracy taught on Henry Street by Lillian Wald and her unique circle will never be superseded. She made the loftiest ideals of America articulate in words and acts. Her disciples and friends carry on her work, some of them in high places.

Her death will sadden thousands whose lives she had touched. But the memory of her warmth and gayety, and of her unaffected love for her neighbors, will long outlive the day of mourning.

• BIRTH • GROWTH • CHILD HEALTH •

The Care of Premature Infants

A Plan of Cooperation Between Hospital and Public-Health-Nursing Services[1]

By Hedwig Koenig, M. D.

From the New York Hospital and the
Department of Pediatrics, Cornell University Medical College

Discussions on the care of the premature infant deal, usually, with his earliest days of life—methods of resuscitation, types of incubators, what and how to feed him, when and with what to bathe him, and how to keep him alive until he weighs enough to be sent home. Little if any emphasis has been placed on the difficulties that may arise after his discharge. Most persons do not realize that such difficulties exist.

Today a plan is to be described wherein a hospital and a visiting-nurse association join to care for the premature infant during this neglected period—the period of transition between hospital and home. While the plan will be given in some detail, I wish first to spend a few moments discussing the reasons why such a plan is necessary. The question may well be asked why there are special problems, since the premature infant is usually kept in the hospital until he weighs at least 5½ pounds—the size of a small full-term infant.

First there is the physical problem. Any 5- to 6-pound baby has little subcutaneous fat; therefore he requires better regulation of the surrounding temperature than does a larger baby. Often he is a feeding problem—he is slow and lazy when nursing, requiring skill and patience on the part of the person who feeds him. He is prone to infections of the skin, of the respiratory and alimentary tracts. To be sure, in all this he differs little from other small babies and it might be well to suggest the use of a plan such as this in the care of any low-weight baby.

But the infant born prematurely has greater claims to special care than the small full-term infant. One claim is perhaps unimportant in the eyes of some but should be briefly mentioned. The cost of a well-staffed unit for premature infants is enormous. Each premature infant therefore represents a large outlay in time and energy, as any nurse working with these infants knows, and of dollars and cents, as any hospital business office will and does loudly testify. It would seem plain common sense to safeguard this investment by every known means.

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[1] Based on paper given at the Second Nursing Institute on Premature Infants, New York, March 29, 1940.

The most compelling claim for added care during the infant's first days at home is almost uniformly overlooked. That is the psychological tangle in which many mothers of such infants find themselves when they are at last faced with the knowledge that they must now be responsible for their babies.

Let us go back and briefly review the series of minor and major shocks which explain the mother's state of mind.

First came the totally unexpected premature labor. Many arrangements for the new baby were still incomplete. Perhaps the other children had to be left without adequate care. Added to these worries about her home was the fear of losing the infant because of his early arrival.

The postpartum period, too, was difficult. She had a baby, but she had never seen him. In the hospital ward her neighbors nursed their infants five or six times daily. She had no infant to nurse. It was not until about the eighth or ninth day that she saw her child and then only briefly through a window. How unsatisfactory not to feel him, hold him, even see all of him! Perhaps she was shocked at his small size. Then came her return home. During the next few weeks the baby seemed less hers than ever.

Finally, when she was strong enough for the trip to the hospital, the situation became worse rather than better. She became more and more impressed with the fact that the hospital considered it necessary to employ trained nurses, gowned and masked, to handle this child which she, the mother, was about to take into her own unskillful hands. The longer the baby stayed, the more she came to doubt her ability to handle him. Many nurses have had the experience of hearing a mother make one excuse after another to avoid taking the infant home. First she asserts that she lacks necessary equipment. When this is provided, she develops a sore throat (without redness, to be sure). Finally, she stays away altogether.

It was to safeguard the health of the child and the investment of the hospital, to help the mother to adust to her baby and the baby to adjust to his home that the following plan was devised for the use of New York Hospital with the aid of the Henry Street Visiting Nurse Service. It followed closely a trial plan used under the guidance of the United States Children's Bureau the year before.

Five or six days after the birth of the infant a medical social worker from the pediatric service visits the mother in the ward. She learns what the economic status of the family is, how many rooms there are in the home, and how many persons occupy these rooms, and, finally, what specific preparations have been made for the care of the infant. Often she finds that the family is entirely sufficient, and she steps out of the picture. Frequently she discovers that help is necessary. It may be merely guidance in purchasing equipment or planning the baby's room. It may be that material help is needed—clothing or a bed. Occasionally she uncovers a situation requiring intensive social service. Obviously, if another social agency is already interested, she puts the problem before its workers, but she sees to it that the responsibility is taken by someone if not by her own organization. A report of her findings is sent to the nursery for premature infants, for the guidance of doctors and nurses.

If the mother has breast milk when she is discharged, a notice to this effect is sent to the district office of the visiting-nurse service. A nurse is sent by them to assist the mother to follow hospital instructions for the maintenance of her milk.

A week before the infant is to be discharged another notice is sent to the district office together with a copy of the social-service findings. The nurse now visits the home to make sure that preparations for the baby's reception are complete. In addition, she notes whether there is infection in the home and whether the mother is well enough to assume the care of the baby.

She reports her findings to the nurse in charge of the premature infant, so that necessary action may be taken by the medical staff, if the infant is to stay in the hospital longer than was planned, or by the social-service staff if it is necessary to send the infant to a boarding home.

Two or three days before the infant's discharge from the hospital the mother is asked to spend part of each day in the nursery, observing the infant and learning to feed him and give him the necessary vitamin supplements, to bathe him, and to prepare the feeding. If she has maintained her breast milk, the baby is taught to nurse.

The day before the infant is discharged a final notice is sent to the district office of the visiting nurse service. This brings the nurse to the home the morning after his arrival to assist with his care. After this the number of visits the nurse makes is determined by the ability or inability of the mother to handle the situation. The nurse always makes at least one more visit, usually she makes four or five, and occasionaly she continues them for months.

What these visits do for the peace of mind of a harassed mother is easy to imagine. To have a professional person advise with her before the infant comes home and promise to return the day after he arrives gives her much-needed confidence. At the hospital we have noted much less reluctance on the part of the nervous mother to take her infant home since this cooperative plan has been in use.

The value of the plan to the hospital may not be so evident. Because the experienced visiting nurse can handle many of the minor problems that arise, reassuring the mother as to stools, hiccoughs, spitting, umbilical hernias, and the dozen other worries the mother with a new infant may have, she prevents many an unnecessary hospital visit. This means that the mother has time to wash the diapers and do the housework instead of sitting for hours in a crowded clinic. It also saves her from exposing her tiny baby to all sorts of infection. On the other hand, if there is something really wrong, if the infant fails to gain weight or seems ill, the nurse can and does encourage the mother to bring the infant to the clinic for medical care. Although it has not been proved statistically, it is believed that hospital admissions have been greatly reduced in the group of infants cared for under this plan. We know that in the past 15 months only 7 of about 130 premature infants have had to be readmitted to the New York Hospital because of infection. The hospital maintains a follow-up clinic for premature infants, and the visiting nurse is of assistance in encouraging regular attendance.

Probably the plan outlined could and in time will be improved, but from it we have learned that the visiting nurse and social-service worker are indispensable in the early care of the premature infant in the home and that they successfully bridge the gap, first between hospital and home and then between home and clinic.

A Unique Experiment in Postgraduate Medical Education

By Jessie M. Bierman, M. D.

Assistant Director, Maternal and Child Health Division, U. S. Children's Bureau

In these days when great emphasis is being placed on postgraduate medical education, it is of interest to observe the success of an experiment in this field which was begun 19 years ago and which has become an established institution. To the Southern Pediatric Seminar at Saluda, N. C., in the Blue Ridge Mountains, a group of general practitioners from all over the South gather each year in July for 2 weeks to learn how they can take better care of the mothers and children in their practices. Their teachers are the leading pediatricians and obstetricians of the South who volunteer their services and pay their own expenses to attend the seminar. Eleven of the twelve surviving members of the original faculty of 16 are still serving, and a number of other faculty members have served for 10 to 15 years. Many of the general practitioners, too, have been back year after year to learn "what's new."

The seminar has had an interesting history. Twenty-six years ago Dr. Lesesne Smith, of Spartanburg, S. C., having observed that his own children recovered from summer illnesses so much more rapidly in the mountains than in the heat of the lowlands, established a small hospital for babies at Saluda where his patients could be cared for during the hot summer months. Provision was made from community funds for free hospitalization of infants whose parents were unable to pay for care. Quarters were provided so that the mothers could remain with their sick children. This arrangement, in addition to giving the mothers also the benefit of the mountain climate, afforded an opportunity to teach them how to take better care of their children.

After a few years Dr. Smith and Dr. Frank Howard Richardson became interested in the idea of affording general practitioners an opportunity to learn more about pediatrics. Their idea met with a cordial response from many of the leading pediatricians of the South. As a result the Southern Pediatric Seminar was organized in July 1921 by the following group of pediatricians and other specialists: Dr. William A. Mulherin, Augusta, Ga.; Dr. Frank Howard Richardson, Brooklyn, N. Y., and Black Mountain, N. C.; Dr. D. Lesesne Smith, Spartanburg, S. C., and Saluda, N. C.; Dr. William P. Cornell, Columbia, S. C.; Dr. R. M. Pollitzer, Charleston, S. C.; Dr. Lawrence T. Royster (then of Norfolk, Va., now of University, Va.) ; Dr. William Weston, Columbia, S. C.; Dr. John LaBruce Ward, Asheville, N. C.; Dr. C. V. Akin, U. S. Public Health Service, Washington, D. C.; Dr. Francis Johnson, Charleston, S. C.; Dr. W. L. Funkhouser, Atlanta, Ga.: Dr. J. D. Love, Jacksonville, Fla.; Dr. Lewis W. Elias, Asheville, N. C.; Dr. E. A. Hines, Seneca, S. C.; Dr. Oren Moore, Charlotte, N. C.; Dr. O. L. Miller, Charlotte, N. C.

Dr. Mulherin, who at that time was chairman of the pediatric section of the Southern Medical Association, was elected dean; Dr. Richardson, vice dean; and Dr. Smith, registrar. The course was established on a nonprofit basis, the students paying a registration fee to cover necessary expenses only.

The first year 5 students attended, the next year there were 21. Since then the average attendance has been 40 to 50, some years reaching as high as 100.

The third year the following persons were added to the faculty: Dr. Owen H. Wilson, of Vanderbilt University, Nashville, Tenn.; Dr. Robert Strong, of Tulane University, New Orleans, La.; Dr. Charles J. Bloom, of New Orleans, La.; Dr. Ross Snyder, of Birmingham, Ala.; and Dr. Stewart Welch, of Birmingham, Ala. Other additions have been made from time to time. Since the death of Dr. Mulherin, Dr. Samuel Ravenel has been elected dean.

The course has come to include lectures and clinical demonstrations dealing with all the common pediatric and obstetric problems a physician is likely to meet in general practice. Each faculty member gives two or three lectures on subjects in which he is especially interested. Infant feeding, the management of diarrhea and enteritis, rickets, care of newborn infants, vitamin deficiencies, chemotherapy, endocrinology, tuberculosis, congenital syphilis, allergy, and child behavior were among the pediatric subjects included at the 1940 session. Some lectures on obstetrics have been included during the past few years. Demonstration well-child conferences have been given to illustrate modern methods of keeping children well. Several of the State health departments of the South have for the past 2 years provided scholarships for their local health officers and health-conference physicians.

Each morning session consists of three lectures and a clinical demonstration. The afternoons are given over to round-table discussions and to well-child demonstrations. Free discussion and an air of informality characterize the sessions. To one familiar with the "lobby sessions" of most medical meetings, the faithful attendance at lectures is striking. A contributing factor may well be the seating arrangements. The seminar hall is equipped with old pullman seats, and one can sit for hours without discomfort. In addition, there is a 10-minute "pause that refreshes" between lectures. Another factor undoubtedly contributing to the friendly atmosphere is the fact that cottages for living quarters are provided, a common dining room is used, and square dances are given on Wednesday nights. Many of the doctors bring their wives, some of whom attend the lectures.

At the close of the session each summer the "student body" has a meeting at which the merits and demerits of the course are discussed and suggestions made to the faculty for improvements for the next year.

Progress Report on Services for Crippled Children

Under Title V, Part 2, of the Social Security Act[1]

By Robert C. Hood, M. D.

Director, Crippled Children's Division, U. S. Children's Bureau

Continued progress has been made in the development of services for crippled children under the Social Security Act. The recommendations of the Advisory Committee on Services for Crippled Children have been accepted by many State agencies, which have translated them into effective action.

Every State is now receiving Federal grants-in-aid for services for crippled children and has an active program in operation.

Crippled children's services in the 51 States,[2] are administered by a variety of agencies; 26 by departments of health, 14 by departments of welfare, 5 by departments of education, 5 by crippled children's commissions, and 1 by a university hospital. Puerto Rico became eligible for Federal aid for this purpose on January 1, 1940, and the Insular Department of Health has prepared a plan of services for the fiscal year 1941. (This was approved July 29, 1940.)

Registration of crippled children is more nearly complete than at any time in the past. At the present time there are more than 250,000 crippled children under 21 years of age on State registers. Progress in State registration of crippled children has been made from year to year and from quarter to quarter since 1936, as shown by the accompanying table.

Growth of State Registers of Crippled Children, Sept. 30, 1936, to Mar. 31, 1940

Quarter ended	Number of crippled children registered	Number of States reporting
Sept. 30, 1936	85, 000	34
Dec. 31, 1936	97, 000	36
Mar. 31, 1937	109, 000	37
June 30, 1937	119, 000	39
Sept. 30, 1937	120, 000	43
Dec. 31, 1937	133, 000	44
Mar. 31, 1938	146, 000	47
June 30, 1938	147, 000	49
Sept. 30, 1938	156, 000	50
Dec. 31, 1938	172, 000	50
Mar. 31, 1939	199, 000	50
June 30, 1939	225, 000	51
Sept. 30, 1939	237, 000	51
Dec. 31, 1939	249, 000	51
Mar. 31, 1940	255, 000	51

The reports on activities under the crippled children's program for the calendar year 1939 show approximately 193,000 visits made to diagnostic and treatment clinics; about 42,000 admissions to hospitals for children who received hospital care totaling 1,400,000 days; approximately 6,500 admissions to convalescent-home care; more than 2,500 to foster-home care; nearly 207,000 visits made by public-health nurses; 172,000 visits by physical-therapy technicians; in addition, 16,000 children were given medical social service; and nearly 4,000 crippled children were referred to the State vocational-rehabilitation agencies.

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[1] This is in substance a report presented before the General Advisory Committee on Maternal and Child-Welfare Services, March 4, 1940. Later information has been incorporated where available.

[2] The term "States," as used throughout this paper, includes Alaska, Hawaii, and the District of Columbia.

A significant item in the program is the improved service given in epidemics. There were rather severe epidemics of poliomyelitis in several States. In South Carolina nearly 500 cases were reported.[3] In this State it was possible to improve early diagnostic and hospital facilities for the care of children affected and to provide for temporary appliances. The State agency also provided in-service training for nurses and workers on its staff and for orthopedic and pediatric consultation services during the epidemic.

The State of Maryland, through a private organization, provided temporary splints for all children who were paralyzed by infantile paralysis during the year. These were made immediately available through the State health department so that any physician could telegraph certain basic measurements and have temporary appliances sent.

A significant factor in the improvement of services in the fiscal year 1940 was the additional funds made available by Congress for the crippled children's program. The original act as passed in 1935 authorized the appropriation of $2,850,000 annually for grants to the States for services for crippled children with the requirement that the grants be matched by the States. Congress in 1939 authorized an additional annual appropriation of $1,000,000 for crippled children's services. This additional money is available for grants to the States on the basis of need, and no requirement is made that these funds be matched by the States. Congress, doubtless, took into consideration the fact that on May 15, 1939, reports from the States showed that there were more than 12,000 children on State registers who were in need of care that could not be provided because of lack of funds.

Of the additional money authorized by Congress, $500,000 was appropriated for the fiscal year ending June 30, 1940, and is being used in part for those States most in need of financial assistance to enable them to care for crippled children. A portion of this fund was set aside by the Children's Bureau for allotments to States which desired to make a beginning in the development of services for children suffering from heart disease and acute rheumatic fever. The Bureau added to its staff a cardiac consultant. Plans which are being worked out in a number of States for services to children with heart disease include provision for the location of children with rheumatic heart disease; arrangements for diagnosis, hospitalization, and convalescent care; and the employment of professional personnel with special training in this field.

There are in this country large unmet needs of handicapped children with many types of crippling other than orthopedic and plastic impairments. For example, it has been estimated that there are approximately 400,000 children suffering from rheumatic heart disease; approximately 60,000 children with severe visual defects; and 7 to 10 million children with refractive errors. Approximately 2 million children have defective hearing, and more than two-thirds of school children have dental defects. The State and Federal funds now available are insufficient to meet these needs.

Since the last meeting of the Advisory Committee on Services for Crippled Children a survey has been made of the types of crippling included on State registers. In a review of 140,000 children on State registers in 1938 it was found that 97 percent were suffering from orthopedic and plastic impairments and only 3 percent from other types of crippling.

A review of reports received on 188,579 children listed on State registers as of December 31, 1939, showed that 19.2 percent of these children had poliomyelitis; 10.2 percent, cerebral palsy, and 2.4 percent, other birth paralyses; 7.3 percent, clubfoot; 5.9 percent, osteomyelitis; approximately 4.4 percent, harelip and cleft palate; 3.8 percent, tuberculosis of the bones and joints; 3.6 percent, scoliosis; 3.0 percent, rickets; and 2.2 percent, burns. The remainder of 38 percent is comprised of "all other known definite diagnoses" and a very small number of "provisional diagnoses."[4]

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[3] *See* The Poliomyelitis Epidemic in Charleston County, S. C., by Margaret Arey, R. N. *The Child,* Vol. 5, No. 2 (August 1940).

It is interesting to note the types of crippling the States are dealing with in their programs and to realize that poliomyelitis does not constitute so great a proportion of the number of crippled children as was believed in the past.

Diagnostic clinics have shown a marked improvement. Progress reports for the year ended June 30, 1939, from 50 States (not including South Dakota) recorded 359 permanent diagnostic clinics and 507 itinerant clinics in operation.

The number of itinerant clinics held for diagnostic services only was 430 and the number held for both diagnosis and treatment was 64. In only 46 of the 507 itinerant clinics was there a pediatrician in attendance. Local physicians attended the majority of these itinerant clinics to observe and many attended the permanent clinics. In 8 States the local physicians attending the clinics assisted with the general physical examination.

Of the 522 hospitals used for crippled children in 50 States reporting, 92 percent were approved by the American College of Surgeons. This is a significant improvement over the preceding year. On the recommendations of advisory committees, Federal and State, the State agencies started their programs by requiring approval by the American College of Surgeons as one of the basic hospital standards. From observation of the type of service provided by hospitals it is apparent that additional standards are needed to indicate whether a hospital is equipped to handle services for crippled children. Each year hospital facilities are improving, and more hospitals are meeting the established standard.

Of the 50 States reporting, 30 States reported the use of 81 convalescent homes for crippled children. Five hundred and twenty-six foster homes were used in 36 of the 50 States. It is now possible to reduce the number of days of hospital care by the more extensive use of convalescent and foster homes.

Certain special projects in the crippled children's program have been continued and extended during the past year. Special services for children suffering from birth palsy carried on in New Jersey, Maryland, Indiana, and Nebraska are being further developed. Speech correction is being provided in Utah and Hawaii for children who have been operated on for harelip and cleft-palate deformities. Summer camps for crippled children are provided in North Dakota, Maryland, and Rhode Island.

A number of States have rounded out their State registers and established approved methods of reporting through the use of Work Projects Administration personnel. Teaching programs for crippled children in their own homes are carried on as WPA projects in Arizona, Colorado, the District of Columbia, and Montana.

The qualifications of the professional personnel employed in the crippled children's program have continued to improve. Of 189 nurses employed under the crippled children's program, 69 had completed an approved course in public-health nursing, 40 had preparation in orthopedic nursing, and 18 had completed an approved course in physiotherapy. Twenty-nine workers employed on State staffs had completed an approved course in medical social work.

The State agencies have continued training programs for State staffs. During the past year 73 persons received training in some field from crippled children's funds. Thirty-five received training in orthopedic nursing, 20 in public-health nursing, 14 in physiotherapy, and 4 in medical social work.

In 24 States a postgraduate course for local physicians was conducted by the State crippled children's agency.

The qualifications of the surgeons providing services for crippled children under State programs have been maintained at a high level. Of the 529 orthopedic surgeons employed by 50 States reporting, 69 percent were certified by the American Board of Orthopedic Surgery, a substantial increase over the number certified in the previous year. Forty-four percent of the specialists in plastic surgery employed by

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[4] Crippling Conditions Found Among Children on State Registers, December 31, 1939 (*Social Statistics*, June 1940, Supplement to *The Child*, Vol. 4, No. 12).

State agencies were certified by the American Board of Plastic Surgery or the American Board of Surgery.

The Social Security Act amendments (approved August 10, 1939) included the provision that the State plans for services for crippled children after January 1, 1940, should include provision for the establishment and maintenance of personnel standards on a merit basis. After consultation with the Federal agencies administering social-security programs and with State officials, the Children's Bureau issued recommended standards for the establishment and maintenance of a merit system of personnel administration, including qualifications for professional employees in the crippled children's program. These were issued for the guidance of the State crippled children's agencies. By March 1, 1940, every State crippled children's agency but 1 had adopted standards for the development of its merit-system plan. (By July 1 every State but 2 had submitted rules and regulations, and review and approval by the Children's Bureau had been completed for 16 States.)

In the development of the crippled children's program the State agencies have continued to seek the cooperation of public and private organizations in this field. At the present time 48 States have general advisory committees on services for crippled children, the members of which are drawn from various organizations and professional bodies. Thirty-three States have technical advisory committees.

A difficult problem for the State agencies is the provision of care for crippled children who have moved across State lines but who have not acquired legal residence in the new State. Reciprocal agreements providing for the care of crippled children moving across State lines are in operation in more than half of the States; only 13 States reported such agreements during the preceding year. Under these agreements the State agencies arrange for care for children from outside their borders, the agency from the State of former residence paying for care until legal residence is established in the new State.

There are many unmet needs in the crippled children's program. The following proposals are presented for its further development:

1. Continuation of emphasis in all phases of the program on improvement in the quality of care.
2. More provision for service for children with types of crippling other than orthopedic and plastic impairments and for crippled children in migratory families and minority groups.
3. Improvement in clinic service to provide for reexamination as well as initial diagnosis; more effective follow-up of recommendations for treatment; more effective coordination of State and local services.
4. Improvement in hospital and convalescent-home standards, with particular reference to the provision of more adequate medical supervision by qualified pediatricians; facilities for the isolation of children on admission to institutions and of those who develop contagious diseases during their sojourn.
5. Universal adoption by State health departments of standard birth certificates with provision for reporting birth injuries and congenital abnormalities.

NOTE

To the members of the Children's Bureau General Advisory Committee on Maternal and Child-Welfare Services listed in *The Child* for August 1940 (p. 55), Dr. Morrey's name should be added as follows:

Lon W. Morrey D. D. S., Chicago, Ill.; Supervisor, Bureau of Public Relations, American Dental Association.

The New York Hospital Quarterly The July 1940 issue of the *Quarterly* published by the Society of the New York Hospital and printed in the New York Hospital Print Shop contains a description of the work for premature babies being done at that hospital, in which the Children's Bureau is cooperating. The article is illustrated with photographs showing equipment and methods of care.

BOOK NOTES

Supervision in Public Health Nursing, by Violet H. Hodgson. Commonwealth Fund, New York, 1939. 376 pp. $2.50.

Mrs. Hodgson's book is a particularly significant addition to public-health-nursing literature, since it is the first book to be devoted exclusively to the subject of supervision in this field.

There is a brief description of the historical development of supervision in public-health nursing. Several of the 20 chapters are devoted to a detailed account of the various organization patterns within which supervision operates.

Throughout the book there is considerable discussion of the philosophy of supervision, based on the principle that true democratic leadership draws on the abilities and intelligence of the staff members and that the aims of the agency are achieved through their growth and development. In view of the present-day emphasis on academic degrees, it is interesting to note that Mrs. Hodgson says, "Knowledge alone does not make a leader." She stresses the more intangible characteristics, particularly ability to work with others.

The greater part of the book is devoted to discussion and evaluation of the tools of supervision—the methods and techniques of supervisory practices. Planned supervision can be effectively put into practice, Mrs. Hodgson believes, through: The principles and methods of teaching; individual and group conferences; records and reports; planned programs for the introduction of personnel to the service; observation visits with staff nurses to the homes and to the clinic; evaluation and rating.

Of distinct interest to Federal, State, and other large nursing services is the chapter on specialized supervision or, as Mrs. Hodgson terms it, specialized consultation. She distinguishes the functions of the specialized supervisor from those of the general supervisor by emphasizing the educational character of the specialist's work and the administrative responsibilities that are usually included in the general supervisor's work.

N. D.

Convalescent Care—Proceedings of the Conference Held Under the Auspices of the Committee on Public Health Relations of the New York Academy of Medicine, November 9 and 10, 1939. New York Academy of Medicine, 2 East One Hundred and Third Street, New York, 1940. 261 pp.

This report of the formal papers and discussion of convalescent care will be welcomed by a variety of professional groups because of the paucity of literature on the subject. The publication of this book was made possible by the financial support of the Josiah Macy, Jr., Foundation and the McGregor Health Foundation. It is not for sale but may be obtained free from the New York Academy of Medicine by professional persons as long as the supply lasts.

The report states that "this conference was national in scope and was prompted by the recognition of the fact that convalescence is a sadly neglected field of medical care." The report is divided into three sections, the first on medical aspects of convalescence, the second on socioeconomic aspects, and the third on a general review of the total situation. The section on medical aspects includes scientific discussion of convalescent care in relation to various types of patients according to specific diseases.

Very informative papers are included also on convalescent care of children and on the convalescence of aged persons. The paper on children calls attention to the fact that "the convalescent home is merely a temporary agency for the care of the child, and his future care is the responsibility of the referring medical agency." As a means of achieving coordination between the referring agency and the convalescent home there is a recommendation for a qualified medical social worker to act as liason officer. A later paper on convalescent care in the home includes a description of a plan for using foster homes for convalescent care of children, which enumerates the advantages of such homes.

Frequent reference is made to the inadequacy of facilities in all parts of the country. "One-half of the convalescent home facilities in the United States are available for New York City residents." There are 24 States that have no convalescent facilities in institutions.

Repeated emphasis is given to the new thought in convalescent care that "the special need of the particular individual who is seeking to regain health, rather than the convalescent care of a case of pneumonia, or rheumatic fever, or appendicitis, is the thing of paramount importance." This emphasis on the need for studying the problem of the individual draws added significance from the fact that "no two diseases can possibly produce the same state of bodily and psychological effects after the illness subsides and convalescence begins."

In a final paper E. H. L. Corwin reviews the lamentable situation in regard to convalescent care which, he says, one of the participants of the conference had aptly called "the unfinished business of medicine." He suggests a number of ways in which more adequate financing might be obtained, among them inclusion of provisions for convalescent care in group-hospitalization plans and in workmen's compensation laws. An earlier speaker suggested that convalescent care should be included in the National Health Bill. There is a broad description of convalescent care as a "creative dynamic force, applied to persons recovering from either acute diseases or operations, or from the exacerbations of chronic maladies, a force which brings into play all the resources of mind and body, of medicine and psychology, to offset the baneful somatic and mental effects of illness. . . . Its aim is restoration of the adult to a state of health, mental poise, and usefulness and of the child to the usual activities of childhood. Convalescent care saves, or should save, the patients the anguish of relapse and of a repeated malady; it saves, or should save, the communities the cost of preventable illness."

M. W. K.

Rheumatic Fever; studies of the epidemiology, manifestations, diagnosis, and treatment of the disease during the first three decades, by May G. Wilson, M. D. Commonwealth Fund, New York, 1940. 595 pp. $4.50.

Dr. Wilson, after more than 20 years' opportunity to observe children with rheumatic fever, has written a book "to present in a systematic way our observations and the factual information we have obtained relative to the etiology, manifestations, course, diagnosis, and prognosis of childhood rheumatism. No attempt has been made to prepare a textbook or a comprehensive critical review of rheumatic fever."

Part I, Epidemiology and Etiology of Rheumatic Fever, contains a detailed account of Dr. Wilson's investigations in the controversial field of the etiology of rheumatic fever. Much of her work on the role of heredity, environment, and streptococcal infection in the causation of rheumatic fever has been published previously; her views that the streptococcus has not been proved to have etiologic significance in rheumatic fever and that hereditary susceptibility underlies the familial incidence of the disease are well-known. Although views and investigations other than the author's are not presented completely, a full bibliography is appended.

Part II, Manifestations of Childhood Rheumatism, Clinical and Pathological, and part III, The Course of Rheumatic Fever in the First Three Decades, are based on the study of 647 patients whose protocols are given in graphic form for the benefit of the careful student of the disease. The data have been analyzed to give information concerning the course and prognosis of rheumatic fever.

Although some general discussion of diagnosis is included, part IV, Diagnosis of Rheumatic Heart Disease in Children, is concerned principally with Dr. Wilson's work in connection with the regression of physical signs, the fluoroscopic examination of the heart, the interpretation of the vital capacity, and exercise tolerance tests. Part V is a brief discussion of The Care and Management of the Rheumatic Child.

B. H.

Let's Talk About Your Baby, by H. Kent Tenney, Jr., M. D. University of Minnesota Press, Minneapolis, 1940. 115 pp. $1.

In Let's Talk About Your Baby, Dr. Tenney, associate professor of pediatrics at the University of Wisconsin Medical School and associate pediatrician to the State of Wisconsin General Hospital, discusses the health aspects of the infant's first year of life.

The book is written in conversational style with an occasional touch of humor. Each of the six chapters represents a health examination of the infant and begins with a monologue by the baby himself. The items of most interest to the mother at the time of each visit are discussed as though the doctor were talking with the mother.

In the first chapter the mother and baby are just leaving the hospital, and many practical suggestions are given in regard to providing for the care of the baby at home.

In the sixth chapter the baby has reached 9 months of age, and the doctor gives advice on many items of concern to most mothers. This chapter concludes with notes for the mother on each of the common diseases of infancy, giving her useful information but not encouraging her to try to treat her child should he become ill.

D. V. W.

The Children's Bureau *does not distribute* the publications to which reference is made in THE CHILD except those issued by the Bureau itself. Please write to the publisher or agency mentioned for all others.

• CHILD WELFARE •
• SOCIAL SERVICES •
• CHILD GUIDANCE •

Care of Children in Their Own Homes Through Supervised Homemaker Service

By Elinore R. Woldman[1]

Chairman, Committee on Supervised Homemaker-Housekeeper Service

Care of children in their own homes is a concept which is steadily increasing in importance as pediatricians, psychiatrists, social workers, and educators grow in their understanding of the significance of the family to the development of the child. To each child his own father, mother, sisters, and brothers—his own family—is his natural habitat and setting. Removal to another setting should be made only when the child's own family group cannot provide him with the opportunity for satisfactory development as an individual and as a member of his community. This accepted principle has served as an impetus to a rapidly growing, relatively new service to families—the supervised homemaker-housekeeper service.

When a mother is temporarily or permanently ill, or is entirely out of the family picture, an increasing number of communities provide this service, thereby enabling children to remain in their own homes. When this service is not available, the illness or death of the mother frequently results in the total disintegration of the family unit with the children placed in institutions or foster homes. As in the case of foster mothers, the social agency selects kindly, understanding, adaptable women, who are given continuous training in child care and household duties. The difference is that in foster-home care it is the child who is removed to the new setting, while in the supervised homemaker service, it is the homemaker or housekeeper who is placed in the family setting. This implies a lesser degree of adjustment on the part of the child, but it necessitates the selection of women who are capable of stepping into a family situation often chaotic because of the mother's illness or death, and who can accept and help maintain the family's pattern of living.

The objective of this service is the preservation of home values and not just the routine accomplishment of household tasks. As the majority of families needing and receiving such service have marginal or less than marginal incomes, ability to stretch the family dollar to provide wholesome nutritious food is a requisite.

In communities where this service is well integrated and understood, the social agency has more suitable applicants for jobs as homemakers than are needed. However, unlike an employment agency, selection of the homemaker is only the first step. When a social agency provides the opportunity for a family to continue as a family unit, two major responsibilities have been assumed:

1. The decision that the particular family needs, desires, and can profit best by this service with full consideration of the advantages and disadvantages of all other available forms of care.
2. The provision that the family unit with the use of the supervised homemaker *continue* to provide maximum opportunity for the healthy, happy development and growth of its family members.

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[1] Mrs. Woldman is supervisor of the Jewish Social Service Bureau, Cleveland, Ohio.

Although each family differs from other families, three general types of situations may be described.

The supervised housekeeper frequently gives temporary or interim care.

For example: Mrs. B must be hospitalized for gallbladder surgery. Mr. B's work at the factory necessitates his leaving home at 7:15 a. m. and returning at 5 p. m. Their three children range in age from a boy of 11 years to a baby of 14 months. There are no interested relatives, and neighbors are too immersed in their own trouble and work to be of any assistance. Mrs. B will be in the hospital for approximately 12 days, and then will be at home in bed for 2 weeks. In order to guard against relapse, further surgery, or incapacity, her convalescence should be geared to her returning strength. Here housekeeper service is needed in order that Mrs. B may go to the hospital relieved of the worry over the care of her children, that the children's school and home routine may not be disrupted, and that Mrs. B may return to her own well-ordered household to convalesce, gradually assuming her household duties as her strength returns. As the number of hours of housekeeper service depends on the family's needs, in this instance the housekeeper would either come in at 7 a. m. and leave at 5 or 5:30 p. m., or would stay nights.

The objective in this interim type of supervised homemaker service is the maintenance of the family unit, routine, and pattern during the temporary absence of the mother from the home. In some communities the need for convalescent homes has been lessened through this service, as the convalescent mother is returned from the hospital or sanitarium to her own home, where she receives care as a member of her family unit.

A second general grouping is that in which the function of supervised homemaker service is to give the family and the case worker a chance to crystallize plans.

For example: Mrs. C died following injuries suffered in an automobile accident. Mr. C comes to the agency asking for plans for care of his four children. Although this is his expressed reason for coming to the agency office, he can talk and think of little else but the fact that he was driving—there was an accident—his wife was hurt—she died. Therefore, he blames himself for her death. He is in no condition to think through long-time plans for the care of his children . Yet they need emergency care. To remove them immediately to a shelter home, a temporary foster home, or institution may mean not only the severing of all home ties but may necessitate replacement or unsatisfactory placement because of the emergency nature of the plan. This was discussed with Mr. C, who gladly welcomed the supervised homemaker plan.

Thus supervised homemaker service may be used as an exploratory plan in order to: (1) Give emergency care to children; (2) give the father an opportunity to think through various plans; (3) offer an actual demonstration of supervised homemaker service to the family without disturbing its usual life routine; (4) afford to the social case worker observational data on the family members and their interrelationships pertinent to the formulation of a plan for long-time care. If placement is indicated, opportunity is thus provided for finding that placement which is best suited to each child.

The third general grouping is that in which it is definitely ascertained that a family needs, desires, and would benefit by the continuation of its family unity, which is made possible by the use of a supervised homemaker.

In such a situation the mother role is assumed by the homemaker under the supervision of the case worker. Here the objective is the maintenance of the household with emphasis on the consistent understanding and affectionate relationship essential for the physical and emotional development of the child. This type of service for want of a better term has been referred to as "inclusive care." Here service may continue as long as the children need it.

Regardless of the stage of development of this service in a given community, there are challenging concepts and problems with an ever-present search for newer, better, additional ways of solving them. For each community separately and individually to work through each step is a costly trial-and-error method. With the recognition of the need for and the value of such a means of care of children, the United States Children's Bureau has responded to the increasing requests for information, guidance, and consultation. In November 1937 a conference on housekeeper service under the auspices of the Children's Bureau was attended by representatives of national and local agencies in the fields of social work, public-health nursing, home economics, vocational training, and the employment of women workers. The need for gathering some data on the actual functioning of homemaker service was indicated, and as a result a study was conducted by a member of the Children's Bureau staff, who visited 17 cities in which various types of housekeeper service were being provided. Information was obtained on the organization, scope of activities, and programs of agencies.[2]

Staff members of agencies providing this service have met informally in 1939 and 1940 to discuss basic problems involved and to arrive at accepted basic concepts. Thus, this Committee on Supervised Homemaker-Housekeeper Service is the present medium of exchange and pooling of experiences, joint thinking, and study. At the meeting at the National Conference of Social Work in Grand Rapids, Mich., in May 1940 the group unanimously agreed that the present informal committee organization should continue. The Children's Bureau agreed to provide services in the circulation of pertinent material, including basic concepts, basic safeguards, illustrations for study and interpretation, and consultation services to those communities and agencies on request.

The next meeting will be held in Cleveland on October 14 and 15, 1940, with the following agenda:

1. Discussion of basic principles.
2. Continuation of discussion of material revealed in 1939–40 committee project. This includes selection of families, training and supervision of housekeepers, and further discussion of suggested terminology.
3. Development of a program of study for the coming winter with the formulation of necessary committees.
4. General plans for the program at the 1941 National Conference of Social Work.

This service is yet in its infancy and only by objective, concerted study and trial can its efficacy be fully realized. It must not be assumed that this form of care is a panacea for all cases involving child care, and caution must be exercised in its application and use.

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[2] Some Characteristics of Housekeeper Services in 10 Agencies. U. S. Department of Labor, Children's Bureau, March 1939. 11 pp. Mimeographed.

Congress Acts to Permit Evacuation of Children From War Zones in American Vessels

On August 27, 1940, the President of the United States approved an act to permit American vessels to assist in the evacuation from the war zones of certain refugee children (Public, No. 776, 76th Cong.). The act is in the form of an amendment to the Neutrality Act of 1939, to section 4 of which it adds a new subsection as follows:

> (b) The provisions of sections 2 (a) and 3 shall not prohibit a vessel, in ballast, unarmed, and not under convoy, and transporting refugee children, under sixteen years of age, from war zones, or combat areas, and shall not prohibit such vessel entering into such war zones or combat areas for this purpose, together with such necessary American citizen adult personnel in charge as may be approved by the Secretary of State, subject to the provisions of the immigration laws, if such vessel is proceeding under safe conduct granted by all of the States named in the proclamations issued under the authority of section 1 (a), and if such vessel has painted on a large scale prominently, distinctly, and unmistakably on each side thereof and upon the superstructure thereof plainly visible from the air an American flag and a statement to the effect that such vessel is a refugee-child rescue ship of the United States or under United States registry: *Provided*, That every such child so brought into the United States shall, previous to departure from the port of embarkation, have been so sponsored by some responsible American person, natural or corporate, that he will not become a public charge.

Questions of ships that can be made available and of obtaining assurances of safe conduct from all belligerents are still being explored.

The Child Guidance Division

The name of the Delinquency Division of the United States Children's Bureau has been officially changed to the Child Guidance Division. The change is in keeping with the work and philosophy of the Division, which is concerned not only with the care of children who have become delinquent but with the early treatment of behavior problems, the prevention of delinquency, and the interrelations of these problems and their treatment with the whole field of child welfare.

BOOK NOTES

Psychiatric Clinics for Children, with special reference to State programs, by Helen Leland Witmer, Ph. D. Commonwealth Fund, New York, 1940. 439 pp. $2.50.

A comprehensive picture is given in this book of the development of psychiatric clinical services for children as well as of the problems that need to be met when such services are conducted under State auspices. The description of the organization and programs of State-conducted clinics for children presented in part II of the volume is based on material collected in a survey conducted under the auspices of the National Committee for Mental Hygiene.

Part I presents the basic psychiatric theory, the evolution of clinical psychiatry in the United States, and the character of the present services of child-guidance clinics and psychiatric clinics. Part II describes the auspices under which State-financed clinics have been conducted, the type of staff employed, the programs of these clinics, and some of their common problems.

The author concludes that although many rural and small-city children have received an understanding examination from State clinics outside urban areas and the interest of teachers, nurses, and social workers in mental hygiene has been fostered, there has been no significant development of local services in the areas served. She suggests that what is needed is some method of working from the local community upward to the facilities of the State rather than a plan that moves in the opposite direction.

In part III the principles for future programs are discussed in the light of some of the obstacles experienced in providing psychiatric service for children under State auspices. Dr. Witmer suggests that many of the problems will disappear when a clinic can clearly define for itself and for the community its own conception of its function. In chapters 10, 11, and 12 she discusses the three objectives that have appeared in the motivation of State clinic-service: (1) The prevention of psychoses and delinquency; (2) the reduction of the number of admissions to State institutions; and (3) the promotion of the mental health of children.

In the discussion of the first of these objectives the findings of studies and the opinions of authorities in these fields are reviewed. The conclusions reached by the author are that potential psychoses can rarely be predicted in childhood, that the complexity of the causal factors in delinquency limits the effectiveness of a clinic in preventing delinquency, and "that psychiatric clinics can give help only with present difficulties and not with future contingencies."

That reduction of the number of admissions to State institutions for mentally defective children can be obtained only through the development of services that will assist in the adjustment of these children in their communities is clearly pointed out in the discussion of the second objective. The author explains that extensive modifications in the training of the staff and in the services provided would be required if clinics are to help parents and teachers of mentally handicapped children to plan for the maximum development of these children.

The discussion of the third objective—that of offering help to children who are handicapped by emotional difficulties—includes a description of basic psychiatric principles and of the differences between child guidance and other forms of child psychiatry. The author discusses the differences of opinion within the child-guidance field concerning the goal of treatment, treatment methods, and the relation of a clinic to the various agencies with which it works, all of which have important consequences for the work of clinics.

In the final chapter the author considers the essential characteristics of an effective program of clinical services for children living in small communities. She also presents some of the practical problems involved in State-supported clinic service, such as: The auspices under which it is conducted, the character and training of the staff, the procedure for providing psychiatric treatment and case-work services, and the relationship between the clinic and the community it serves.

M. R. C.

Public Assistance, Vol. I.—American Principles and Policies, by Edith Abbott. University of Chicago Press, Chicago, 1940. 894 pp. $4.50.

In this first volume on Public Assistance, Miss Abbott has discussed comprehensively pertinent American principles and policies. Through some 700 pages of selected documents which include excerpts from State laws, court decisions, governmental reports, and other material, the student of public welfare has been provided with a wealth of material illustrating public-assistance philosophy and practice from colonial times to the present day. The documents selected show not only the progress that has been made but the confusion that has accompanied many of the efforts to develop a more humanitarian approach to the problems of persons in need.

The material is presented in five parts: The Principle of Public Responsibility; The Old Poor Law in the Twentieth Century; Local Responsibility and Medical Care; State Grants-in-Aid for Public Assistance; and Federal Aid and Emergency Relief. Each part is preceded by an introduction to the documentary material in which Miss Abbott expresses her own philosophy clearly and objectively, together with the basis for her opinion.

Miss Abbott points out that, although public responsibility for those in need has been an established policy in the United States, poor laws have failed to define just what persons are entitled to relief. She is convinced that sufficient funds will not be available everywhere to aid those who are in need so long as administration remains in the local jurisdictions. She calls attention to the extremities to which poor persons are frequently driven in their attempts to prevent suffering on the part of members of their families and recommends that the old pauper laws be abolished or be rewritten in line with modern social-welfare programs.

Miss Abbott makes a plea for removal of local settlement provisions to make it possible for assistance to be given wherever and whenever need is discovered.

In the section devoted to transient or "unsettled" poor the author suggests that more equitable treatment would be possible if relief for the destitute migrant could be given on a national basis. She proposes that grants to States for assistance be made available through a Federal bureau to transients, contingent on the adoption of proper State regulations regarding settlement, particularly legislation which will make it impossible for a person to lose settlement in one place before he has acquired it elsewhere. She regards a uniform 1-year settlement law as practical and possible and believes a real effort should be made to secure agreement for a law of this kind in all the States.

Miss Abbott describes graphically the indignities and inadequate care which human beings have been forced to endure because medical care has remained a local responsibility. She agrees heartily with the conclusion of the Interdepartmental Committee to Coordinate Health and Welfare Activities that the only way out of this difficulty is to make provision for Federal aid and some plan of financial cooperation between the State and the Federal Government which will make possible minimum health and medical services to the needy sick.

The author gives a detailed discussion of the historical background for State grants-in-aid and describes the struggles that took place in the early days of the depression between the proponents of public relief and persons who believed that the need could be met through private charity.

Attention is called to the evidence furnished by the depression that adequate relief can be obtained only through a public relief system with State and Federal funds to supplement the inadequate funds of the minor local authorities and a State administrative authority to standardize on a higher level and make uniform the widely varying methods of giving relief that are used by local authorities within a single State.

After describing the history of Federal aid in the nineteenth century and the attempts at Federal assistance under the Reconstruction Finance Corporation and the Federal Emergency Relief Administration, Miss Abbott concludes with the opinion that the Federal Emergency Relief Administration represented great gains in the relief program and in the national social-welfare program. Nevertheless, she finds the relief situation in many sections of the country just as tragic when the Federal Emergency Relief Administration came to an end in 1935 as it had been before the Federal relief act was passed.

In her second volume Miss Abbott plans to discuss the new forms for public aid which have been developed since the passage of the Social Security Act and the administration of work relief.

M. R. C.

ROOMS OF THEIR OWN; a survey of 28 Lower East Side Social Clubs, by Emeric Kurtagh, George Stoney, and Walter S. Child. Henry Street Settlement, 265 Henry Street, New York, June 1939. 79 pp. 50 cents.

Twenty-eight "cellar clubs" of lower east-side New York were studied in the course of this survey to determine their nature, purpose, and the differences among them. These social clubs, all located near the Henry Street Settlement, had very limited financial resources and consequently rented the cheapest rooms available. Boys and young men of like background and experience organized the clubs for social purposes. The age span for the individual club was seldom more than 4 years. The 707 club members had an average age of 24 years. The average age for one club was 17 years, and the average age of another was 35 years.

The Henry Street Settlement made this study because little was known about the 5,000 or more cellar clubs in New York City. The cooperation of the Federation of East Side Clubs was obtained in making the study, and a part of the report considers the activities of the federation itself. Three general types of clubs were found: (1) The closed or closely knit group; (2) the institution club, which is composed of a large membership divided into smaller groups; and (3) a "casual" or "jazz" club, which does not have a definite organization.

The study shows the spontaneous development of the clubs, the need of the club member to have a place of his own where he can have some privacy, the meager facilities of most of the clubs, and their need for assistance and guidance in program planning. The survey also emphasizes the need for a more inclusive study of social clubs.

As a study of recreational and social activities in a metropolitan area this should be of special interest to persons concerned with settlement activities.

D. H. F.

AN ADOPTED CHILD LOOKS AT ADOPTION, by Carol S. Prentice. D. Appleton-Century Co., New York, 1940. 222 pp. $2.

The author of this book, who was herself an adopted child and is also an adopting parent, has succeeded admirably in discussing objectively some of the problems and adjustments which must be faced in connection with adoption. When her own adoption took place few safeguards had been set up. She is fully appreciative of the value of present-day safeguards and discusses them in the light of her own experiences and those of her friends and acquaintances, some of whom were sadly disappointed in their adventures into the field of adoption.

Stories of actual adoptions have been selected to illustrate some of the general questions pertaining to adoption. The author discusses the selection of the right home for the right child, the need for understanding the motives behind a desire to adopt a child, the relative importance of heredity and environment in adoption, some of the problems that must be faced in rearing a foster child, and the difficulties that may develop in bringing up own and adopted children in a single family.

A manual for adopting parents and a short bibliography are included.

LIFE, LIBERTY AND THE PURSUIT OF BREAD, by Carlisle Shafer and Carol Shafer. Columbia University Press, New York, 1940. 207 pp. $2.25.

The authors of this book have departed from traditional method in their presentation of pertinent fundamental problems found in every community which is at all aware of its social needs. The social-worker wife in letters to her husband, a teacher of social sciences, poses certain questions based on the individual problems of persons who have come to her attention in the course of her day-by-day work in a county relief office. These questions—which concern unemployment, low income, old age, broken homes, and health care—are answered in the letters from the husband.

The net result is a thought-provoking discussion with a distinct air of reality and a basis of social principles that are sound, if somewhat academic.

The chapter on fatherless homes concerns the problems of a mother in pursuit of security for her four children. In the final chapter on social work the wife endeavors to interpret social work to her somewhat skeptical husband.

The purpose of the book is summed up by the husband when he says, "Social scientists too often view humanity only in the abstract. Social workers too often see it only in the personal. Together we can reach a truer, more satisfactory view."

IN A MINOR KEY: Negro youth in story and fact, by Ira DeA. Reid. American Council on Education, Washington, 1940. 135 pp. $1.25.

This presentation of some problems of Negro youth confronting American democracy was prepared by Ira DeA. Reid for the American Youth Commission. The information given is in reference to the everyday realities of health, housing, education, vocational guidance and opportunity, and social planning and security. Any youngster in high school can identify himself and his problems with this material. Any adult attempting to fulfill his responsibility to young persons can perceive the challenge.

Each chapter is presented "in story" and "in fact." The fact is statistical material in narrative form. The story is a sociological interpretation of the information. Together they explain the significance of handicaps under which Negro youth grow up.

As a whole the book is highly objective. If it were not for the author's wit and humor the stark realities he has assembled might be more depressing than challenging. Each chapter has quotable passages.

The book does not claim to be conclusive, since it deals with a subject that is more heavily laden with story than with fact. For example, there is evidence of the short span of Negro youthhood—evidence that social and emotional adulthood descends quickly on chronologically youthful shoulders—but there is little accumulated knowledge on this subject. The author states and interprets problems of Negro youth, the solution of which must spring from the forces of social planning.

V. L.

EDUCATION AND ECONOMIC WELL-BEING IN AMERICAN DEMOCRACY. Educational Policies Commission, Washington, 1940. 227 pp. 50 cents.

How universal public education is related to the economic well-being of the country is the subject considered by the Educational Policies Commission of the National Education Association of the United States and the American Association of School Administrators in another of its studies in the series on education and democracy. The commission points out the extent to which immediate financial expediency, without regard to long-range effects, governs the present educational system. It deals with the contributions which education, both general and occupational, makes to productivity and with the amount of education necessary to achieve maximum productivity after paying the costs of education. Methods of selecting students for advanced training on the basis of ability rather than financial resources are discussed. The commission presents an estimate of the annual cost of a system of education which would make for maximum economic efficiency and suggests ways of financing it.

Although the commission as a whole had an active part in the preparation of this report and approved it for publication, Dr. John K. Norton had the chief responsibility for writing it.

ELEMENTARY EDUCATION; what is it? by Helen K. Mackintosh. Federal Security Agency, U. S. Office of Education. Bulletin 1940, No. 4, Part I. 31 pp.

This bulletin is the first of four proposed publications based on reactions to the committee reports presented during a conference on elementary education held at the Office of Education in June 1938.

This volume gives a bird's-eye view of elementary education—its nature and importance, together with its relation to and contribution to the whole process of education.

• CHILD LABOR •

• YOUTH EMPLOYMENT •

• VOCATIONAL OPPORTUNITIES •

Expediting the NYA Program

By Mary H. S. Hayes, Ph. D.

Director, Division of Youth Personnel, National Youth Administration, Washington, D. C.

Since it was established by President Roosevelt over 5 years ago, the National Youth Administration has opened new frontiers for American youth by providing them with the opportunity to earn and to learn.

The old opportunities inherent in a new Nation, with vast areas of free land and a hand-labor economy, vanished when the last homesteads were taken up, when giant corporations replaced individuals as the owners of our factories, and when the machine displaced human labor along the assembly line of mass-production industry.

Consequently, the National Youth Administration has geared its program to prepare young men and young women for such opportunities as exist in a machine age.

The ability of a large number of young men, and young women, too, to earn a living in the modern world requires their learning a mastery of the machine. Need for knowledge of machinery and of mechanical work of various kinds has become increasingly apparent as a result of the emphasis on national defense.

Quite logically, therefore, the National Youth Administration is placing increasing emphasis on projects which will provide young people with basic work experience and related training in various types of mechanical work.

Because of the increasing demand on the part of young people for elementary training of the kind provided on NYA work projects and to facilitate expansion of mechanical projects, the National Youth Administration has taken a number of steps to "streamline" its program.

The first of these steps was initiated by issuance of instructions to State Youth Administrators to expand the employment of youth in workshop projects.

A survey which was made in May 1940 showed that there were slightly over 38,000 young people employed in more than 2,000 NYA workshops. In addition to woodworking units these shops included 406 automotive units, 374 metal and mechanical units, 195 radio and electrical units, 67 airplane units, and 226 others of various types.

Under a program which is now going forward, employment of youth in shops of the various kinds is being brought up to 75,000. In many instances it is possible to double the employment in existing units by working two shifts instead of one. Other shops are being enlarged and provided with additional equipment.

In recent months the National Youth Administration has given mechanical-ability tests to 13,638 young men working in 590 shops in 43 States. These tests, which are a standardized form developed for use in the Navy Department and the Tennessee Valley Authority, reveal a high degree of mechanical ability in this group of needy young people. This indicates that among youth who have not the opportunity to attend trade and mechanical schools, there is a great untapped reservoir of ability which can be directed into mechanical pursuits of value to the Nation at this time.

About 50,000 more forms for use in giving these standard tests have been distributed recently to NYA State offices. The test results will give NYA supervisory personnel another tool for determining those young people who are most likely to be successful in exacting mechanical work.

The second step taken by the National Youth Administration to expedite its program was a redefinition of the requirements for eligibility for employment on the work program for young people 18 and over not in school. The requirement as to need now is defined to read as follows: "A youth shall be eligible for certification if he is in need of employment, work experience, and training."

Heretofore under the various relief acts, certification to the National Youth Administration has required a consideration of the needs of the entire family on a budget basis, and nearly all NYA youth have come from families on relief. The new definition will make it possible to reach needy youth coming from marginal groups and to select youth for NYA projects on the basis of their own need for employment and their suitability for the type of work provided by the project.

The third step taken by the National Youth Administration to expedite its program has been the initiation of a plan for increasing the number of young people enrolled in resident projects.

Resident work centers have been developed by the National Youth Administration for two reasons: First, to provide employment for isolated youth coming from rural communities where the number in any one community is not large enough to justify a local project; second, to obtain for certain youth the more extended program and the values that come from congregate living.

National Youth Administration architects have developed plans, which have been forwarded to State offices, for a new and improved type of "resident center" that will soon be under construction. The new center is of modern functional design and is planned to accommodate about 200 young people. Each standard unit for 200 youth has five workshops and five dormitories. The number of buildings and the number of employees may vary from the standard units somewhat to fit local needs and conditions. It is expected that at least one of these new and improved centers will be started in each State before the end of the year.

This increase in the employment of young people in resident projects is expected to result in a better background of work experience for them. By bringing youth together in larger units it will be possible to provide better equipment, better supervision, and thus to turn out more efficient work. Health activities, citizenship classes, and self-government can be more readily carried on in connection with resident units than with local units.

The fourth step taken by the National Youth Administration to expedite and improve its program is the development of a plan for enlarged health activities. Although in the past the National Youth Administration has done considerable work to build up the health of young people and to improve health services in the communities in which NYA projects operate, there has been a need for extension of this work.

To facilitate the expansion of its health program, the National Youth Administration has secured the loan of a medical officer from the staff of the United States Public Health Service who will work with staff members in the central office and with State Youth Administrators in developing activities best suited to local needs.

The fifth step taken by the National Youth Administration has been the conclusion of an agreement with the United States Office of Education and State departments of education whereunder the National Youth Administration will rely on the school system to provide related training, both academic and vocational, for its project workers unless school officials report that their facilities are not adequate for this task.

In the past the National Youth Administration had set up some training classes of its own, many of them in resident projects located in isolated regions where school facilities were lacking. Under the new policy an effort will be made to transfer all such training classes to the local schools. It is hoped that this new policy will develop a coordinated effort at vocational training which will improve the quality of both work experience and classroom activities.

Ever since its establishment, the National Youth Administration has sought to induct youth into employment in private industry through cooperative arrangements with State employment services. As a means of bringing this about it has financed and effected the establishment of junior divisions of public employment services in 41 States. Since July 1940 all these divisions have been taken over and completely financed by the State employment services.

The extent to which the work projects for out-of-school youth under the National Youth Administration are contributing to national defense is incapable of exact measurement, but it can be demonstrated that the type of work experience and training provided to youth on NYA projects is of great value to them in securing private employment when jobs are available. Last year the turn-over of employment on NYA work projects was at a rate higher than 100 percent annually. Between one-third and one-half of young people who leave NYA projects do so to take private employment.

Coal-Mine Order Issued Under Hazardous-Occupations Program

By Elizabeth S. Johnson

Assistant Director in Charge of Research, Industrial Division, U. S. Children's Bureau

The Fair Labor Standards Act of 1938, while in effect establishing a basic minimum age of 16 years for employment in all industries subject to its child-labor provisions, recognizes the social waste of allowing young persons to engage in dangerous work and sets up machinery for establishing a minimum age of 18 years for employment in hazardous occupations.[1] This is done by giving to the Chief of the Children's Bureau the power to find and by order declare occupations particularly hazardous for the employment of minors between 16 and 18 years of age or detrimental to their health or well-being; after such a determination has been made, and an order issued, an 18-year minimum age is in effect in the particular occupations covered by the order.

The first application of the 18-year minimum-age standard for hazardous occupations to a major national industry came with the issuance by the Chief of the Children's Bureau of Order No. 3, applying to coal mines. Previous orders relating to hazardous employment affect work in manufacturing explosives (Order No. 1) and the occupations of motor-vehicle driver and helper (Order No. 2).

When the Children's Bureau was given this responsibility for finding and declaring occupations particularly hazardous for minors, it was faced with the need for developing a method of making factual determinations in a field where uniform standards and criteria for research methods had not been established to any considerable extent. As the first step in its program for administering this provision of the act, the Bureau planned a framework for its procedure which was outlined in Regulation No. 5, Procedure Governing Determinations of Hazardous Occupations. It is only as investigations and findings in several fields have progressed, however, that the Industrial Division of the Bureau has gradually developed in detail research methods especially suited to making the determinations of fact that are necessary for giving effect to the policy of the act with respect to hazardous occupations.

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[1] The Fair Labor Standards Act of 1938 provides in sec. 12 (*a*) that "no producer, manufacturer, or dealer shall ship or deliver for shipment in [interstate] commerce any goods produced in an establishment . . . in or about which . . . any oppressive child labor has been employed," and defines "oppressive child labor" in sec 3 (*l*) in part as "a condition of employment under which . . . any employee between the ages of 16 and 18 years is employed by an employer in any occupation which the Chief of the Children's Bureau in the Department of Labor shall find and by order declare to be particularly hazardous for the employment of children between such ages or detrimental to their health or well-being . . ."

The methods of investigating the hazards for minors in the coal-mining industry and of formulating the finding and order finally issued as Order No. 3 illustrate the way in which the Bureau has so far developed its procedure for exercising its responsibility of finding and defining occupations to which in policy the act applies an 18-year minimum-age standard.

In choosing coal mining as the first major field for study the Bureau was guided by the advice of its Advisory Committee on Occupations Hazardous for Minors, which was organized to advise the Bureau on policy matters in the field of hazardous occupations and is composed of experts in industrial health and safety, employer and labor representatives, and others concerned with the welfare of young workers.[2] In the past the industry had used large numbers of boys (approximately 16,000 coal-mine workers were under 18 years of age according to the census of 1930), and it has been customary in some sections of the industry for boys about 16 years of age to start under the supervision of an experienced miner at the underground work of removing coal from the face, where there is constant danger of falls of roof and coal, and to perform other tasks involving risk of accident.

In carrying out the investigation and in formulating the order defining the hazardous occupations in coal mining the Division, in accordance with the advice of its Advisory Committee, cooperated closely with groups in the coal-mining field, seeking technical assistance and welcoming advice regarding its investigation and regarding the content and wording of an order. Those consulted included representatives of mine operators, of labor groups, and of State mine and labor departments and other persons interested in mine safety and employment of minors in the industry. From the very beginning and throughout its study the Division worked closely with the United States Bureau of Mines, receiving invaluable technical assistance from this agency.

The Industrial Division's work of investigation followed several lines. Visits were made by the safety engineer on the Division's staff to coal mines of various types in several States for the purpose of analyzing occupations and hazards. Statistics of coal-mine accidents, based chiefly on comprehensive data available from the United States Bureau of Mines, were analyzed for a 5-year period and compared with accident rates for manufacturing as a whole, based on data furnished by the Bureau of Labor Statistics. Legal minimum-age standards for coal-mine work and available data on current policies and practices of the industry regarding the employment of minors under 18 were reviewed. Problems of the legal implications of an order were studied, and definitions of terms to be used were carefully developed so that the intended application of the order in terms of actual mining conditions would be clear to mine operators and workers affected as well as to the staff of the Bureau responsible for the administration of the order.

In compiling results of the investigation and research in this field and drawing conclusions, a group of technical advisers, most of whom had been consulted during the early phases of the study, were asked to make suggestions, corrections, or additions to a draft of the report of investigation submitted to them and to give their reactions to a tentative draft of the order.[3] Many valuable suggestions were received and made use of.

The culmination of the investigation work preparatory to issuance of an order was the submission to the Chief of the Children's Bureau of the Industrial Division's report of investigation and her issuance of a proposed finding and order based on it. This report shows that work in and about coal mines, both anthracite and bituminous, involves an exceptionally high degree of accident risk in comparison not only with manufacturing as a whole but also with most other industries for which adequate injury statistics are available; that all underground occupations, all occupations in open-pit operations, and many surface occupations involve serious accident hazards; and that State legislation, reflecting public recognition of the particular hazards of coal-mine work for young people, has established higher minimum-age standards for work in or about coal mines than for general employment in the majority of the coal-producing States.[4]

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[2] A list of the members of the Committee appeared in the February 1939 issue of *The Child*, Vol. 3, No. 8, p. 177.

[3] The Bureau's group of technical advisers on coal mining was composed of the following persons: C. E. Berner, superintendent, Coal Mine Section, Pennsylvania Compensation Rating and Inspection Bureau; Harvey Cartwright, National Coal Association; Waldo Fisher, Department of Industry, Wharton School, University of Pennsylvania; O. E. Gasaway, International Executive Board Member of the United Mine Workers of America; Daniel Harrington, Chief, Health and Safety Branch, U. S. Bureau of Mines; D. C. Kennedy, National Coal Association; C. A. McDowell, secretary, Mine Inspectors' Institute of America; R. H. Moore, National Coal Association; J. H. Oliver, Anthracite Institute; Joe Ozanic, president, Progressive Mine Workers of America; N. P. Rhinehart, chief, West Virginia Department of Mines.

The proposed finding and order relating to coal-mine occupations, issued by the Chief of the Bureau on June 7, 1940, was wide in its coverage of occupations in the industry, declaring as hazardous all work in or about coal mines, except a few surface occupations. The excepted surface occupations were slate picking at a picking table in a tipple or breaker and occupations requiring the performance of duties solely in offices or in repair or maintenance shops.

Opportunity for review of the proposed finding and order and for the making of suggestions and objections was afforded by the distribution of notice of the proposal and of a hearing to be held June 28, 1940. These notices were mailed to national labor associations of coal-mine workers, national trade associations of anthracite and bituminous operators, individual coal-mine operators, trade publications, and State labor and mine departments and other agencies or individuals known to be interested in coal-mine safety or the employment of young persons in coal-mine work.

At the hearing, which was attended by representatives of the Anthracite Institute (trade association of anthracite operators), the National Coal Association (trade association of bituminous operators), the United Mine Workers of America (Congress of Industrial Organizations), the Progressive Mine Workers of America (American Federation of Labor), and the National Child Labor Committee, the proposed finding and order met with general favor.

As a result of suggestions presented at the hearing a minor revision in the proposed order was made, namely, to include as an exempted surface occupation slate picking at chutes as well as at picking tables. No objections showing just cause for further change in the proposed revision, which was publicly announced, were received; and the final order relating to coal-mine occupations was issued on August 1 to become effective September 1, 1940.

The statement of the occupations covered by the order is as follows:

Order.—Accordingly, I hereby declare that all occupations in or about any coal mine, except the occupation of slate or other refuse picking at a picking table or picking chute in a tipple or breaker and occupations requiring the performance of duties solely in offices or in repair or maintenance shops located in the surface part of any coal-mining plant, are particularly hazardous for the employment of minors between 16 and 18 years of age.

> *Definitions.*—For the purpose of this order—
>
> (1) The term "coal" shall mean any rank of coal, including lignite, bituminous, and anthracite coals.
>
> (2) The term "all occupations in or about any coal mine" shall mean all types of work performed in any underground working, open-pit, or surface part of any coal-mining plant that contribute to the extraction, grading, cleaning, or other handling of coal.

This action, which marks a cardinal achievement in the long-time effort to protect boys from the serious hazards of coal-mine work, comes fortunately at a time when relatively little displacement of young workers will be involved in adjusting to the 18-year standard, since—because of the extent of adult unemployment in coal-mine localities—comparatively few minors under 18 appear to be currently employed in the industry. Nevertheless, the order is particularly timely now, because the impending expansion of employment in the industry in connection with preparations for national defense, without the 18-year standard would lead almost inevitably to an increased use of boys at unduly hazardous work.

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[4] The Hazards of Coal-Mine Employment for Young Workers, a Report of Investigation Made Under the Child-Labor Provisions of the Fair Labor Standards Act Regarding the Hazardous Nature of Coal-Mine Occupations for the Purpose of Determining Whether Employment in Such Occupations Is Particularly Hazardous for Minors Between 16 and 18 Years of Age. Washington, June 7, 1940. 74 pp. Mimeographed.

NEWS NOTES

Meeting of Advisory Committee on Occupations Hazardous for Minors

The Children's Bureau Advisory Committee on Occupations Hazardous for Minors met on June 27, 1940, to discuss realignment of the hazardous-occupations program in the light of expanding production in industries affected by the defense program.

It was the consensus of opinion at the committee meeting that the two most important fields in which investigations should next be undertaken were shipbuilding and the operation of metalworking machinery, the investigation of the latter to cover types of machines used in airplane manufacture. It was also recommended that action in the health-hazard field should be taken as soon as the Bureau could make the necessary preliminary investigations.

The Industrial Division has readjusted its earlier plans and is undertaking immediately investigations in the first two fields. As soon as the pending investigations of logging and sawmilling and of the operation of woodworking machinery are completed, it will be possible to concentrate efforts on these new fields where prompt action is particularly important if hazardous-occupation standards are to be set for young workers before many are taken on in hazardous jobs.

Age certificates for children working in sugar-beet and sugarcane production

The plan for issuing age certificates, or proof-of-age cards, for children between 14 and 16 years of age under the Sugar Act of 1937,[1] which was tried out in Ohio, Michigan, and Louisiana in 1939 in cooperation with the Sugar Division of the Department of Agriculture, is in operation this year for children employed in sugar-beet and sugarcane production in these three States and four additional States: Iowa, Montana, Nebraska, and Wyoming. These certificates are not issued for children under 14 years of age.

Under the act the Children's Bureau has no powers of enforcement but hopes to encourage compliance by making available certificates of age in cooperation with State and local officials in charge of certificate issuance. The responsibility for obtaining compliance with these child-labor standards rests with the Department of Agriculture, the agency administering the act.

Publications of Division of Labor Standards

Bulletins recently issued by the Division of Labor Standards of the United States Department of Labor include the following:

Occupational Poisoning in the Viscose Rayon Industry, by Alice Hamilton, M. D. Bulletin No. 34, Washington, 1940. 79 pp. This describes the processes in which toxic hazards exist, general plant problems, the effects of carbon-disulphide poisoning and hydrogen-sulphide poisoning, and the maximum allowable concentration of carbon disulphide and hydrogen sulphide in the air of workrooms. The bibliography of 53 items includes references in French, Italian, and German.

Discussion of Industrial Accidents and Diseases. Bulletin No. 36, Washington, 1940. 190 pp. This contains the proceedings of the twenty-sixth annual convention of the International Association of Industrial Accident Boards and Commissions, held in Milwaukee in September 1939.

Protecting Eyes in Industry. Bulletin No. 37, Washington, 1940. 18 pp. In this bulletin are given the addresses presented before the Industrial Section, National Society for the Prevention of Blindness at its Annual Conference in New York City, October 27, 1939.

Safeguarding Manpower for Greater Production. Special Bulletin No. 1, Washington, 1940. 20 pp. The importance of safe working conditions in maintaining and increasing industrial output for national defense is the subject of this bulletin, which deals with physical conditions in work places, sanitation and hygiene, and safety practices. Selected references are given on industrial safety and health.

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[1] *See* Age Certificates for Young Workers Under the Sugar Act, by Ella Arvilla Merritt. *The Child*, Vol. 4, No. 4 (October 1939).

U S GOVERNMENT PRINTING OFFICE · 1940

• EVENTS OF CURRENT INTEREST •

CONFERENCE CALENDAR

Oct. 5–10	National Society for Crippled Children. Annual convention, Asheville, N. C. Permanent headquarters: Elyria, Ohio.
Oct. 6–8	Seventh Institute on Public Health Education. Detroit, Mich. Under the auspices of the Public Health Education Section of the American Public Health Association.
Oct. 8–11	American Public Health Association. Sixty-ninth annual meeting, Detroit. Permanent headquarters: 50 West Fiftieth Street, New York.
Oct. 7–11	National Safety Council. Chicago. Permanent headquarters: 20 North Wacker Drive, Chicago.
Oct. 21–24	American Dietetic Association. Twenty-third annual meeting, New York.
Nov. 8–9	Society for Research in Child Development. Fourth biennial meeting. Harvard Medical School, Boston, Mass. Secretary-Treasurer: Carroll E. Palmer, M. D., Society for Research in Child Development, 2101 Constitution Avenue, Washington, D. C.
Nov. 10–16	American Education Week. Twentieth anniversary. Information and program material from National Education Association, 1201 Sixteenth Street NW., Washington, D. C.
Nov. 12–14	Seventh National Conference on Labor Legislation. Called by the Secretary of Labor, Washington, D. C.
Nov. 12–15	Southern Medical Association. Thirty-fourth annual meeting, Louisville, Ky. Permanent headquarters: Empire Building, Birmingham, Ala.
Nov. 13–15	National Association of Day Nurseries. Second annual conference, New York. Permanent headquarters: 122 East Twenty-second Street, New York.
Nov. 18–20	American Academy of Pediatrics. Annual meeting, Memphis, Tenn. Secretary-Treasurer: 636 Church Street, Evanston, Ill.
Dec. 9–12	American Farm Bureau Federation. Annual convention, Baltimore, Md.

UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF

THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives THE CHILD.

THE CHILD is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to the editor, THE CHILD, Children's Bureau, United States Department of Labor, Washington, D. C.

THE CHILD is for sale by the Superintendent of Documents, Washington, D. C., at $1 a year; foreign postage, $0.50 additional. Single copies are 10 cents each. Subscription orders should be addressed to the Superintendent of Documents, Government Printing Office, Washington, D. C.

Social Statistics

Supplement Number 1, September 1940

to

THE CHILD—Volume 5, Number 3

Published by the
CHILDREN'S BUREAU
U. S. DEPARTMENT OF LABOR
WASHINGTON, D. C.

SUPERINTENDENT OF DOCUMENTS
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SOCIAL-STATISTICS SUPPLEMENT

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Hospital In-Patient Service, January-June 1940, and Trends in Patient-Days, 1936-39- 7

The SOCIAL-STATISTICS SUPPLEMENT is issued by the Children's Bureau four times a year, in connection with the Bureau's monthly publication, THE CHILD.

The purpose of the supplement is to make available for general use summaries of current social statistics related to child welfare, prepared by the Bureau's Division of Statistical Research. While material presented in the supplement will be based largely on reports forwarded by health and social agencies in connection with the Bureau's project for the registration of social statistics, closely related material from other sources will also appear from time to time.

UNITED STATES DEPARTMENT OF LABOR
FRANCES PERKINS
SECRETARY

CHILDREN'S BUREAU
KATHARINE F. LENROOT, Chief

PATIENTS SERVED BY MEDICAL-SOCIAL-SERVICE DEPARTMENTS

For the past several years the Children's Bureau, in cooperation with the American Association of Medical Social Workers, has provided medical-social-work departments of hospitals and clinics of certain urban areas with standard report forms and instructions and furnished guidance in the reporting of medical-social-work statistics. It was recognized at the start of this reporting plan in 1928, when a joint committee was organized by the American Association of Medical Social Workers and the social-statistics project, that any attempt to measure the work done in this field in a standardized manner would require considerable time and experimentation. The activities carried on by medical-social-work departments have varied considerably—from minor services and assistance in administrative duties to concentration on full service and treatment of cases. The number of departments whose activities consist largely of full treatment and service has been increasing slowly in these urban areas.

During the first years of the reporting plan an attempt was made to classify cases by type of service provided. The extreme difficulties of classifying cases in this manner led to the abandonment of the plan in 1938. It was generally recognized at that time that the function of current statistical reports should be limited, at least for the present, to reporting on the total number of patients served, and that analyses of the service should depend on special reports. Certain definitions were adopted for purposes of reporting to give some assurance that greater comparability in reports might be expected as the definitions were more carefully applied: (1) A medical-social-service department was defined as a separately organized department of a hospital or clinic. (2) The services to be counted were defined as those that involve consideration of the patient as an individual and of the interrelationship of medical and social factors. By this definition reporting of routine or clerical services was eliminated. (3) Services reported were expected to have been permanently recorded. In applying these general limitations considerable responsibility was left to the person locally in charge of reporting. These definitions undoubtedly prevent the receipt of reports from medical social workers in some hospitals and clinics where the work may not be carried on in agreement with these conditions.

Certain data from the resulting reports for the calendar year 1939 are presented here. In connection with these figures it should be borne in mind that a number of hospitals and clinics in an area may not have an organized medical-social-work department meeting the definition adopted for this reporting project. Furthermore, the care given to patients by medical-social-work departments still ranges from minor service to full service and treatment; these differences may be found within the same department as well as between departments. The absence of a standard with which the amount of service rendered can be compared is a serious limitation. No measure has yet been widely adopted to indicate the number of medical-social-work patients that might be expected in an area or in an individual hospital or clinic.

Number of patients served during 1939.—As has been stated, the departments reporting in the project are those connected with hospitals or with separately organized clinics. The urban areas in which these departments are located are all participating in the Children's Bureau project for the collection of social statistics. The 19 areas from which figures are given here each submitted reports covering at least 80 percent of the medical social service provided in the area.

During 1939 an average of 26,136 patients per month were reported as receiving medical social service in the 19 areas. In New Orleans, the area where the largest number of patients were given service during any one month, a few more than

4,700 patients were reported as the monthly average. Six of the areas reported a monthly average of less than 500 cases (table 1). During the year the admissions to medical social service in the 19 areas reached a total of slightly more than 130,000. This indicates that approximately 145,000 patients, including those under care at the beginning of the year, were served during the year.

Service rendered in relation to potential need.--Although it is not possible to determine precisely the adequacy of this service some very rough measurement may be made of the probable number of persons who are potential subjects for medical social service in the 19 areas, with which existing services may be compared. It is difficult to limit to any one group the hospital patients who would benefit from medical social service. The total number of ward patients would be used if available but an even more conservative figure, used here, is the number of free patients, excluding pay or part-pay ward patients. The number of free hospital patients plus the number of clinic patients is taken to represent the total number of potential subjects for medical social service.[1]

The figures available for recent months indicate that there were more than 650,000 free patients served by the hospitals of these 19 areas during 1939. Likewise it appears that there were about 1,650,000 clinic patients served during the same year. Clearly, not all clinic or free in-patients would be in need of intensive medical social work, but the figure of 2,300,000 patients represents a possible total. The 130,000 admissions actually reported by medical-social-work departments during the year constitute between 5 and 6 percent of the computed potential number of patients. This indicates roughly how few of the potential patients actually receive this specialized service.

Trial estimates for the individual areas indicate that only 3 of the 19 areas reported total admissions to medical social service during the year equal to more than 10 percent of the estimated potential number of patients: The highest percentage was 18. In 4 areas the total admissions amounted to less than 2 percent of the potential number of patients.

Public and private agencies.--In the 19 areas private agencies predominated. Private departments reported an average of 17,493 cases per month in these areas and public agencies, an average of 8,643. Ten areas did not report any departments under public auspices. In this connection it is well to recall the limitations set up for the reporting project. It is possible that medical social workers may be employed in other hospitals and clinics of these areas, but the departments are not considered locally to be providing service as defined for inclusion in this reporting project.

Monthly rate of turnover.--The monthly rate of turnover in cases varied widely but was rapid in almost all areas, averaging 0.7 for all departments together, 0.4 for the 14 public departments, and 0.9 for the 59 private agencies. This means that on the average admissions to service during a month were equal to seven-tenths of the number of patients under care at the beginning of the month. An average monthly turnover rate of 1.0 would mean that the number of admissions during the month equaled the number of cases under care at the beginning of the month. These figures are affected by the type of care provided and by the extent to which care is continued after discharge from the hospital or throughout clinic attendance. The average length of stay in general hospitals, which account for the great majority of the medical social service reported, is usually from 10 to 15 days. One factor in accounting for the difference in ratio for public and private departments may be the longer average length of stay in public hospitals as compared with private hospitals. Corresponding figures on the average length of intensive treatments at clinics are not available. Clinic patients, however, would undoubtedly be under treatment for a considerably longer time than hospital in-patients, and the monthly turnover rate would therefore tend to be much lower.

Change by month.--The monthly figures for 1939 showed a fairly consistent upward trend during the year, covering any seasonal variations

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[1] In Hospital Survey of New York (United Hospital Fund of New York, 1937) a similar measurement was developed. The "potential work unit" referred to there was made up of ward patients plus the estimated number of clinic patients. The practice of estimating an average of 5 clinic visits per patient as a means of calculating the number of clinic patients, used in the New York study, has been followed in the present article.

Table 1.--Selected summary statistics reported by 73 medical-social-work departments in 19 urban areas, 1939

Area, and type of department	Number of departments	Average monthly number of patients during 1939			Average monthly rate of turnover
		Number under care at beginning of month	Number accepted for service	Number receiving service	
Total, 19 areas	73	15,239	10,897	26,136	0.7
Public	14	6,242	2,401	8,643	0.4
Private	59	8,997	8,496	17,493	0.9
Baltimore (all private)	5	836	1,832	2,668	2.2
Buffalo	3	629	805	1,434	1.3
Public	1	160	573	733	3.6
Private	2	469	232	701	0.5
Cleveland	6	1,688	1,915	3,603	1.1
Public	1	166	172	338	1.0
Private	5	1,522	1,743	3,265	1.1
Denver	2	97	82	179	0.8
Public	1	48	18	66	0.4
Private	1	49	64	113	1.3
Detroit (all private)	5	1,107	773	1,880	0.7
Grand Rapids (all private)	2	320	77	397	0.2
Hartford (all private)	3	311	240	551	0.8
Louisville (all public)	1	405	126	531	0.3
Milwaukee (all private)	1	110	18	128	0.2
New Haven (all private)	1	164	61	225	0.4
New Orleans	4	3,535	1,183	4,718	0.3
Public	1	3,342	907	4,249	0.3
Private	3	193	276	469	1.4
Pittsburgh	14	960	733	1,693	0.8
Public	1	53	37	90	0.7
Private	13	907	696	1,603	0.8
Richmond (all public)	1	213	120	333	0.6
St. Louis (all private)	5	1,524	738	2,262	0.5
St. Paul (all public)	3	858	273	1,131	0.3
Springfield, Mass. (all private)	1	80	130	210	1.6
Syracuse (all private)	5	373	346	719	0.9
Washington, D. C.	9	1,843	1,061	2,904	0.6
Public	4	997	175	1,172	0.2
Private	5	846	886	1,732	1.0
Wilkes-Barre (all private)	2	186	384	570	2.1

Table 2.—Average monthly number of patients reported by 73 medical-social-work departments in 19 urban areas, first quarter, 1939 and 1940

Area, and type of department	Number of depart- ments	Average monthly number of patients receiving service		Percent change first quarter 1939 to first quarter 1940
		First quarter 1939	First quarter 1940	
Total, 19 areas	73	23,592	28,397	+20
Public	14	7,366	10,503	+43
Private	59	16,226	17,894	+10
Baltimore (all private)	5	2,524	2,670	+6
Buffalo	3	1,453	1,759	+21
Public	1	786	873	+11
Private	2	667	886	+33
Cleveland	6	3,137	3,471	+11
Public	1	325	413	+27
Private	5	2,812	3,058	+9
Denver	2	202	132	-35
Public	1	90	39	-57
Private	1	112	93	-17
Detroit (all private)	5	2,044	1,647	-19
Grand Rapids (all private)	2	382	352	-8
Hartford (all private)	3	599	640	+7
Louisville (all public)	1	550	542	-1
Milwaukee (all private)	1	133	137	+3
New Haven (all private)	1	213	232	+9
New Orleans	4	3,755	5,756	+53
Public	1	3,404	5,224	+53
Private	3	351	532	+52
Pittsburgh	14	1,560	1,714	+10
Public	1	82	131	+60
Private	13	1,478	1,583	+7
Richmond (all public)	1	246	414	+68
St. Louis (all private)	5	2,151	2,447	+14
St. Paul (all public)	3	842	1,460	+73
Springfield, Mass. (all private)	1	193	221	+15
Syracuse (all private)	5	645	762	+18
Washington, D. C.	9	2,389	3,513	+47
Public	4	1,041	1,407	+35
Private	5	1,348	2,106	+56
Wilkes-Barre (all private)	2	574	528	-8

that might exist. The number of cases was lowest in January (22,009 patients) and highest in November (28,240). Other reports of clinic visits received in the Children's Bureau project for the registration of social statistics indicate a marked change during a year, but the figures for the summer months have generally been among the highest. On the other hand, the rate of occupancy in hospitals is generally lowest during the summer months. These differences in seasonality would tend to offset each other when medical-social-work reports for clinics and for hospitals are combined.

First quarter of 1940 compared with first quarter of 1939.--That the increases in the monthly figures throughout 1939 largely represented an upward trend rather than seasonal variations is also shown by a comparison of the average monthly figures of total patients served for the first quarter of 1939 with similar figures available for 1940. The figure for the 19 areas in 1939 was 23,592; in 1940, 28,397. Increases were reported by both public and private agencies, the increase for all public agencies amounting to 43 percent and among private agencies to 10 percent. Only five of the areas reported decreases during this period (table 2).

Staff of medical-social-work departments.--During 1939 the Children's Bureau attempted to obtain certain information on the staff of medical-social-work departments. A tabulation of personnel assigned to in-patient service and clinic service for the 62 departments reporting sufficiently complete data showed that the median number of patients served per worker was 92 a month. The assistance received from supervisors and from student workers would reduce this figure in many departments.

HOSPITAL IN-PATIENT SERVICE, JANUARY-JUNE 1940 AND TRENDS IN PATIENT-DAYS, 1936-39

Nearly half (47 percent) of the total number of patient-days reported by hospitals of 30 urban areas during the period January through June 1940 were provided free to patients. In the same period children admitted to hospital care made up 16 percent of the total admissions. The total patient-days provided by hospitals in 18 urban areas during the year 1939 were 8 percent more than the number of patient-days provided in 1936. The private-hospital service in these 18 areas showed some increase in each year of the period 1936-39, while the volume of public-hospital service remained nearly constant.

These figures are based on reports received by the Children's Bureau as part of its project for the registration of social statistics.[1] Data in this article relate to services of general hospitals and hospitals of certain special types, including children's, maternity, isolation, and orthopedic hospitals. Hospitals that limit their care to patients with tuberculosis and patients who are chronically ill are omitted since they usually offer more prolonged treatment than do most of the special types.[2]

IN-PATIENT SERVICE OF 30 URBAN AREAS, JANUARY-JUNE 1940

A tabulation of in-patient service in 30 urban areas during the period January through June 1940, which includes detail by area, will be found in table 3 (p. 10). The data for each of the 30 urban areas represent at least 80 percent of the in-patient services provided by hospitals of the types included in this report.

Admissions to In-Patient Service

Children receiving hospital care constituted 16 percent of the total admissions in the 30 areas.[3] The average proportion of children's admissions to total admissions was 17 percent in public hospitals and 15 percent in private hospitals. Special hospitals of certain types, however, gave a much larger percentage of their services to children (fig. 1). A summary showing the total admissions and the number of children's cases and maternity cases admitted to public and private hospitals of the 30 urban areas is given in table 1. In table 2 total admissions and children's admissions are given by type of hospital.

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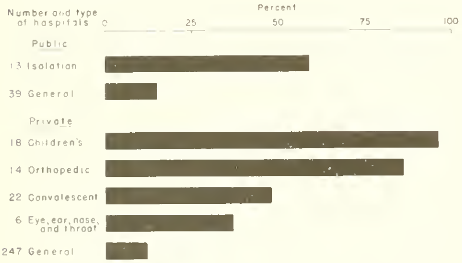
[1] Similar reports on general hospital services during 1936, 1937, and 1938 were included in *Social Statistics* for September 1937 and for March 1939.

[2] The social-statistics project does not include reports from the few hospitals in the areas covered that are organized for profit, nor those operated by industrial or commercial establishments and caring only for their own employees. It is further limited to exclude hospitals such as those caring for the insane, feeble-minded, epileptic, blind, or deaf; marine hospitals; and hospitals for ex-soldiers.

FIG.1.—RATIO OF CHILDREN'S TO TOTAL ADMISSIONS, BY TYPE OF HOSPITAL, JANUARY—JUNE 1940



Of the 30 areas New Orleans reported the highest proportion of children's admissions, 20 percent of total admissions. In 19 other areas the proportion of children's admissions was as high as 15 percent, and in no area was the proportion lower than 10 percent. In 11 of the 27 areas that reported services by public hospitals 20 percent or more of the admissions to public hospitals were of children. In 4 areas--Springfield, Mass., Syracuse, Wilkes-Barre, and Grand Rapids--where the number of children's admissions to public hospitals was more than 40 percent of the total, all the children reported received care in isolation hospitals. The ratio of children's admissions to total admissions in private hospitals of the various areas ranged from 10 to 22 percent.

Since in many hospitals all beds may be occupied either by adults or by children, it is difficult to estimate the proportion of hospital facilities normally available for the care of children. In comparison with the 16 percent of total admissions reported here as accounted for by children, it is interesting to note that the Committee on Medical Care for Children of the 1930 White House Conference estimated that only about 8 percent of the total number of beds in hospitals of the United States were for children.[4]

Fourteen percent of the total admissions in the 30 areas were maternity cases. The ratio of admissions for maternity service to total admissions in the various areas ranged from 10 to 21 percent.

Average Length of Stay

The average length of stay per patient in the general and special hospitals of these 30 areas was 17 days in public hospitals and 11 days in private hospitals.

The public hospitals showed wide variation from area to area in the average length of stay per patient. For all areas except Springfield and Pittsburgh the range was from 9 to 30 days. In Springfield, where the average length of stay per patient reached 64 days, the public hospital for isolation service also offers service to tuberculous patients. The average length of stay of 53 days in Pittsburgh includes care of chronically ill persons who are served in one public general hospital.[5] The average length of stay in private

Table 1.—Type of admissions to hospital in-patient service; 30 urban areas, January-June 1940

Type of admissions	Total (382 hospitals)	Public hospitals	Private hospitals
Total...........	868,124	223,030	645,094
Children under 14....	135,154	37,011	98,143
Maternity cases......	124,495	26,361	98,134
Other...............	608,475	159,658	448,817

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[3] Statistics on children admitted to in-patient service as requested by the Children's Bureau are limited to children under 14 years of age and do not include infants born in the hospital. The figures reported in this item by a few hospitals, however, do not include children between the ages of 12 and 14 years. Some other hospitals include children to 16 years.

[4] White House Conference on Child Health and Protection: Hospitals and Child Health, p. 5. Century Co. (now D. Appleton-Century Co.), New York, 1932.

[5] Although hospitals caring only for tuberculous patients and chronically ill have been omitted from tabulations in this article, the tabulations do include care provided to such cases as part of the service of general hospitals and hospitals of the special types that are included.

Table 2.—In-patient service provided by hospitals of specified types; 30 urban areas, January-June 1940

Type of hospital	Number of hospitals	Admissions: Total	Admissions: Children under 14: Total	Admissions: Children under 14: Percent of total admissions	Patient-days: Total	Patient-days: Percent of total: Free	Patient-days: Percent of total: Pay and part-pay
Total	382	868,124	135,154	16	12,453,032	47	53
Public	61	223,030	37,011	17	4,233,327	93	7
General	39	206,522	30,040	15	3,766,763	93	7
Isolation	13	9,262	5,432	59	332,624	98	2
Other	9	7,246	1,539	21	133,940	100	......
Private	321	645,094	98,143	15	8,219,705	23	77
General	247	599,734	69,290	12	7,402,155	19	81
Children's	18	24,580	23,636	[a]96	322,712	60	40
Orthopedic	14	1,535	1,326	86	150,277	91	9
Convalescent	22	2,355	1,140	48	138,042	85	15
Maternity	12	7,233	54	1	135,856	14	86
Eye, ear, nose, and throat	6	7,281	2,697	37	34,610	22	78
Other	2	2,376	....	....	36,053	23	77

[a] Not all children's hospitals limit admissions to children under 14 years of age.

hospitals in all the areas was between 8 and 14 days.

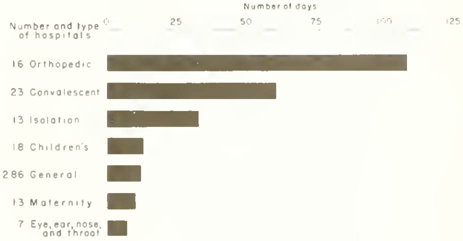
A graphic comparison of the average length of stay in hospitals of different types is presented in figure 2.

Percentage of Occupancy

The Committee on Medical Care for Children of the 1930 White House Conference, in reviewing the hospital situation, considered that a hospital regarded as filled to capacity should operate with 80 or even 85 percent of its beds occupied.[6] During the period January through June 1940 the average percentage of occupancy of general and special hospitals in the 30 urban areas was 76. The average among public hospitals (81 percent) for all areas was considerably higher than that among private hospitals (74 percent).

Although the occupancy of public hospitals varied widely among the areas (from 7 to 89 percent) the rate was less than 70 percent in only 7 areas, and in 5 of these the majority of public hospital beds were for isolation cases. The range of occupancy rates for private hospitals in the 30 areas was from 64 to 87 percent, half the areas showing from 75 to 85 percent.

FIG. 2.—AVERAGE LENGTH OF STAY PER PATIENT, BY TYPE OF HOSPITAL, JANUARY-JUNE 1940



Pay Status

It is estimated that free hospital care was provided to nearly 350,000 of the 980,556 individuals (including infants born in the hospital) who received service in public and private hospitals in the 30 urban areas during the period January

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[6] See ftn. 4, p. 8.

Table 3.--In-patient service provided by general and special hospitals[a] in 30 urban areas, January-June 1940

Area, and type of hospital administration	Number of hospitals	Admissions				Patient-days			Admissions and live births	Average length of stay per patient in days[b]	Percent of occupancy
		Total	Percent of total			Total	Percent of total				
			Children under 14	Maternity cases	Other		Free	Pay and part-pay			
Total	382	868,124	16	14	70	12,453,032	47	53	980,556	13	76
Public	61	223,030	17	12	71	4,233,327	93	7	244,358	17	81
Private	321	645,094	15	15	70	8,219,705	23	77	736,198	11	74
Akron (all private)	5	12,303	18	16	66	135,249	25	75	14,194	10	82
Atlanta	9	21,266	11	18	71	229,773	53	47	24,631	9	79
Public	3	9,163	9	25	66	101,798	100	......	11,044	9	78
Private	6	12,103	12	13	75	127,975	16	84	13,587	9	80
Baltimore	23	48,289	18	14	68	891,506	57	43	54,238	16	80
Public	3	10,355	15	19	66	299,324	88	12	12,105	25	89
Private	20	37,934	20	12	68	592,182	41	59	42,133	14	76
Birmingham	8	13,870	18	14	68	152,559	63	37	15,544	10	74
Public	2	5,621	14	24	62	73,647	100	......	6,747	11	84
Private	6	8,249	22	7	71	78,912	28	72	8,797	9	66
Buffalo	15	29,792	15	17	68	519,572	49	51	34,361	15	81
Public	1	5,028	8	7	85	162,610	83	17	5,332	30	84
Private	14	24,764	16	19	65	356,962	34	66	29,029	12	79
Canton	4	6,904	10	21	69	74,823	14	86	8,284	9	69
Public	1	831	3	25	72	9,180	6	94	1,030	9	50
Private	3	6,073	11	21	68	65,643	15	85	7,254	9	73
Chicago	62	156,844	16	14	70	2,104,943	45	55	176,767	12	75
Public	5	46,237	20	9	71	773,462	99	1	48,881	16	89
Private	57	110,607	14	17	69	1,331,481	13	87	127,886	10	68
Cleveland	19	49,198	12	16	72	751,918	41	59	56,543	13	83
Public	3	8,692	8	13	79	243,219	86	14	9,717	25	79
Private	16	[c]40,506	13	17	70	508,699	20	80	[c]46,826	11	86
Columbus	9	16,564	15	15	70	229,073	30	70	18,804	12	75
Public	1	2,830	9	14	77	38,267	49	51	3,195	12	74
Private	8	13,734	16	15	69	190,806	26	74	15,609	12	76

Dallas	6	19,324	15	14	71	194,537	42	58	21,517	9	76
Public	1	5,114	9	19	72	53,780	97	3	5,772	9	76
Private	5	14,210	17	12	71	140,757	21	79	15,745	9	75
Dayton (all private)	4	11,452	12	19	69	149,023	36	64	13,464	11	75
Des Moines	6	10,104	16	12	72	105,603	30	70	11,210	9	73
Public	2	2,343	29	9	62	23,957	99	1	2,523	9	79
Private	4	7,761	12	13	75	81,646	10	90	8,687	9	71
Detroit	26	74,179	14	16	70	1,133,395	50	50	85,694	13	77
Public	5	20,744	12	10	78	491,069	88	12	22,638	22	86
Private	21	53,435	15	19	66	642,326	21	79	63,056	10	72
Duluth	4	8,124	14	12	74	95,665	39	61	9,035	11	78
Public	2	1,182	14	....	86	15,035	100	......	1,182	13	72
Private	2	6,942	14	14	72	80,630	28	72	7,853	10	79
Grand Rapids	8	8,255	17	18	65	112,561	32	68	9,578	12	68
Public	3	357	41	....	59	7,257	83	17	357	20	45
Private	5	7,898	16	18	66	105,304	28	72	9,221	11	71
Kansas City, Mo.	13	24,901	17	11	72	342,557	46	54	27,418	12	76
Public	2	7,310	13	12	75	121,876	97	3	8,044	15	73
Private	11	17,591	18	10	72	220,681	18	82	19,374	11	78
Milwaukee	18	37,140	18	13	69	422,049	38	62	41,813	10	60
Public	4	12,846	19	6	75	133,817	98	2	13,538	10	52
Private	14	24,294	18	17	65	288,232	11	89	28,275	10	64
New Haven (all private)	4	11,797	13	13	74	173,804	21	79	13,240	13	83
New Orleans	8	50,184	20	10	70	628,932	76	24	54,505	12	77
Public	1	30,594	24	11	65	452,015	100	......	33,172	14	77
Private	7	19,590	12	9	79	176,917	16	84	21,333	8	79
Omaha	11	17,341	11	12	77	259,058	46	54	19,191	13	70
Public	3	3,147	14	11	75	99,429	100	......	3,436	29	80
Private	8	14,194	11	12	77	159,629	13	87	15,755	10	66
Pittsburgh	31	57,699	15	16	69	945,770	36	64	66,035	14	77
Public	2	1,176	30	....	70	62,103	96	4	1,176	53	84
Private	29	56,523	15	16	69	883,667	32	68	64,859	14	76

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[a] Does not include special hospitals caring for the tuberculous, chronically ill, insane, feeble-minded, epileptic, blind, or deaf.

[b] Computed by dividing the number of patient-days provided during the period January-June 1940 by the number of admissions and live births during that period.

[c] Based on discharges since private hospitals in Cleveland classify patients discharged rather than admissions. During the period covered in the table, the actual number of admissions and live births exceeded the number of discharges and deaths by less than one-tenth of 1 percent.

Table 3.--In-patient service provided by general and special hospitals[a] in 30 urban areas, January-June 1940--Continued

Area, and type of hospital administration	Number of hospitals	Admissions				Patient-days			Admissions and live births	Average length of stay per patient in days[b]	Percent of occupancy
		Total	Percent of total			Total	Percent of total				
			Children under 14	Maternity cases	Other		Free	Pay and part-pay			
Richmond............	6	7,006	19	16	65	145,184	70	30	7,783	19	84
Public............	3	4,914	23	17	60	118,738	75	25	5,405	22	88
Private............	3	2,092	10	15	75	26,446	48	52	2,378	11	68
St. Louis............	24	50,400	14	13	73	787,949	50	50	56,317	14	74
Public............	4	15,614	12	13	75	294,887	100	......	17,339	17	80
Private............	20	34,786	14	14	72	493,062	21	79	38,978	13	72
St. Paul............	11	21,775	18	12	70	342,089	49	51	24,313	14	77
Public............	2	5,460	29	10	61	156,835	97	3	5,956	26	75
Private............	9	16,315	14	13	73	185,254	9	91	18,357	10	79
San Francisco........	15	32,497	15	10	75	533,621	47	53	35,431	15	81
Public............	2	11,950	9	7	84	247,574	86	14	12,594	20	84
Private............	13	20,547	18	12	70	286,047	13	87	22,837	13	79
Sioux City...........	5	7,237	16	10	74	71,450	13	87	7,927	9	64
Public............	1	19	37	....	63	303	100	......	19	16	7
Private............	4	7,213	16	10	74	71,147	12	88	7,908	9	66
Springfield, Mass....	5	8,496	18	16	66	131,600	30	70	9,739	14	73
Public............	1	187	68	....	32	11,942	81	19	187	64	63
Private............	4	8,309	17	17	66	119,658	24	76	9,552	13	74
Syracuse............	6	12,866	14	15	71	171,421	35	65	14,535	12	84
Public............	1	316	49	....	51	5,898	83	17	316	19	39
Private............	5	12,550	13	16	71	165,523	33	67	14,219	12	87
Washington, D. C.....	13	35,386	18	16	66	527,900	54	46	40,605	13	80
Public............	2	10,877	14	17	69	234,154	98	2	12,530	19	81
Private............	11	24,509	20	15	65	293,746	20	80	28,075	10	79
Wilkes-Barre.........	4	6,931	15	16	69	89,448	57	43	7,840	11	67
Public............	1	123	44	....	56	1,151	89	11	123	9	53
Private............	3	6,808	15	16	69	88,297	56	44	7,717	11	67

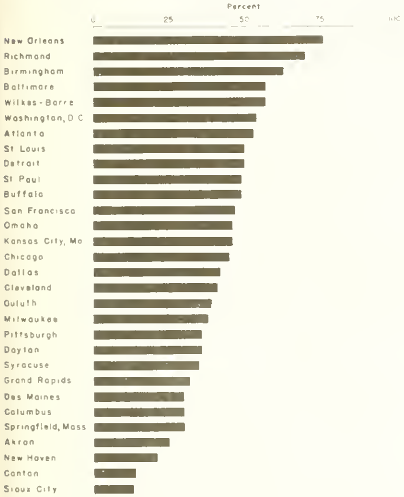
[a] Does not include special hospitals caring for the tuberculous, chronically ill, insane, feeble-minded, epileptic, blind, or deaf.

[b] Computed by dividing the number of patient-days provided during the period January-June 1940 by the number of admissions and live births during that period.

through June 1940. Free patient-days,[7] exclusive of free service provided on a part-pay basis, amounted to 93 percent of the total reported by public hospitals and to 23 percent of the patient-days reported by private hospitals.[8]

The volume of free patient-days ranged from 13 to 76 percent of the total days' care provided in the various areas (fig. 3). In 20 of the 27 areas that reported public-hospital service more than 85 percent of the public service was provided without any charge to the patient. Public hospitals in 7 of these areas reported 100 percent free service, and in 8 additional areas the proportion of free care provided was more than 95 percent of the total. In only 2 areas was the free service reported by public hospitals less than 75 percent of the total patient-days.

FIG.3 - FREE PATIENT-DAYS PROVIDED BY HOSPITALS AS PERCENTAGE OF TOTAL, JANUARY-JUNE 1940



Private hospitals in 17 of the 30 areas gave more than 20 percent free service. Wilkes-Barre was the only area that reported free care amounting to more than 50 percent of the patient-days provided in private hospitals.

Among the public hospitals a higher percentage of free care was reported by special hospitals than by general hospitals (table 2, p. 9). Public-isolation hospitals reported 98 percent free service and the other special hospitals under public auspices reported that all services provided were free. Among the private hospitals, orthopedic, convalescent, and children's hospitals had the highest proportions of free to total patient-days.

TREND IN PATIENT-DAYS, 1936-39

Data showing trend in patient-days during the calendar years 1936 through 1939 are given in table 4 (p. 14). This tabulation includes 18 of the 30 areas for which hospital service during the period January through June 1940 has already been summarized.[9]

The number of patient-days provided during the calendar year 1939 by 218 general and special hospitals in the 18 urban areas showed an increase of 8 percent over the number provided during 1936. This increase occurred almost entirely in the services provided by hospitals under private auspices, which showed an increase of 11 percent in 1939 as compared with 1936. In the 18 areas as a whole almost no change took place in the number of patient-days provided by public hospitals.

All the 18 areas except Sioux City showed some increase in the total patient-days provided during 1939 as compared with 1936. Although showing practically no change for the 18 areas combined, the amount of care provided by public hospitals varied widely among the areas. With the exception of Duluth, however, the increases and

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[7] Free patient-days as used in this article are defined as patient-days provided to patients to whom it was agreed upon admission that no charges would be made. This includes patient-days provided to patients using endowed beds and to patients whose bills are paid from public funds, from funds of a community chest or other financial federation, or from the funds of a private social agency.

[8] Summary financial reports for 1938 received from hospitals in 20 of the 30 areas provide another means of measuring the percentage of free care provided. In these areas public hospitals reported 89 percent of their current income for 1938 from sources other than patients who pay for service, and private hospitals reported 24 percent of their current income for the same year from sources other than patients.

[9] The differences between the number of hospitals reported in the trend tabulation and the number reported January through June 1940 for these 18 areas are due to incomplete reporting during the 4-year period. The few hospitals omitted from the trend, however, are not sufficiently large to reduce the coverage of any area below the minimum of 80 percent.

Table 4.—Patient-days provided by general and special hospitals[a] in 18 urban areas, 1936-39

Area, and type of hospital administration	Number of hospitals 1939	Patient-days 1936	1937	1938	1939	Percent change from 1936 to 1939
Total	218	12,655,551	13,341,849	13,369,165	13,639,299	+8
Public	31	4,004,176	4,014,590	4,034,752	4,005,609	....
Private	187	8,651,375	9,327,259	9,334,413	9,633,690	+11
Akron (all private)	4	193,062	207,759	203,817	232,854	+21
Buffalo	14	926,702	921,790	967,907	977,422	+5
Public	1	345,193	329,686	322,240	329,712	-4
Private	13	581,509	592,104	645,667	647,710	+11
Chicago	52	3,236,973	3,390,956	3,405,749	3,498,066	+8
Public	3	1,260,345	1,282,572	1,341,164	1,337,355	+6
Private	49	1,976,628	2,108,384	2,064,585	2,160,711	+9
Cleveland	19	1,333,586	1,402,265	1,403,952	1,424,255	+7
Public	3	504,660	509,639	501,738	477,549	-5
Private	16	828,926	892,626	902,214	946,706	+14
Columbus	9	396,344	412,671	425,398	427,807	+8
Public	1	68,274	66,889	67,904	70,877	+4
Private	8	328,070	345,782	357,494	356,930	+9
Dayton (all private)	4	226,208	255,159	263,056	279,255	+23
Des Moines	6	191,148	202,200	204,802	202,075	+6
Public	2	44,184	54,158	48,458	52,652	+19
Private	4	146,964	148,042	156,344	149,423	+2
Detroit	23	2,034,854	2,185,264	2,135,291	2,098,433	+3
Public	5	947,615	1,014,017	984,131	954,972	+1
Private	18	1,087,239	1,171,247	1,151,160	1,143,461	+5
Duluth	4	153,129	170,015	171,216	186,042	+21
Public	2	23,118	29,613	29,590	33,912	+47
Private	2	130,011	140,402	141,626	152,130	+17
Grand Rapids	7	153,145	190,530	203,073	199,664	+30
Public	2	8,464	9,803	12,857	12,750	+51
Private	5	144,681	180,727	190,216	186,914	+29
Milwaukee	15	714,930	712,118	711,755	724,184	+1
Public	4	309,183	249,037	264,250	271,906	-12
Private	11	405,747	463,081	447,505	452,278	+11
New Haven (all private)	3	266,790	282,744	286,077	309,927	+16
Pittsburgh	28	1,440,000	1,563,276	1,533,148	1,601,390	+11
Public	2	134,229	124,612	117,589	118,430	-12
Private	26	1,305,771	1,438,664	1,415,559	1,482,960	+14

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[a] Does not include special hospitals caring for the tuberculous, chronically ill, insane, feebleminded, epileptic, blind, or deaf.

Table 4.--Patient-days provided by general and special hospitals[a] in 18 urban areas, 1936-39--Continued

Area, and type of hospital administration	Number of hospitals 1939	Patient-days				Percent change from 1936 to 1939
		1936	1937	1938	1939	
St. Paul	11	603,111	619,182	626,663	634,059	+5
Public	2	327,459	304,003	312,733	310,266	-5
Private	9	275,652	315,179	313,930	323,793	+17
Sioux City	4	106,921	104,418	101,209	101,380	-5
Public	1	3,884	2,874	1,346	538	-86
Private	3	103,037	101,544	99,863	100,842	-2
Springfield, Mass	5	232,469	239,475	235,064	245,102	+5
Public	1	16,835	21,576	22,246	21,442	+27
Private	4	215,634	217,899	212,818	223,660	+4
Syracuse	6	297,017	327,044	325,781	331,945	+12
Public	1	9,739	14,999	7,828	11,821	+21
Private	5	287,278	312,045	317,953	320,124	+11
Wilkes-Barre	4	149,162	154,983	165,207	165,439	+11
Public	1	994	1,112	678	1,427	+44
Private	3	148,168	153,871	164,529	164,012	+11

[a] Does not include special hospitals caring for the tuberculous, chronically ill, insane, feeble-minded, epileptic, blind, or deaf.

decreases of more than 10 percent were mainly accounted for by changes in the volume of service provided by isolation hospitals. In Duluth an increase of 47 percent occurred in the number of patient-days provided by 2 public general hospitals.

Private hospitals showed increases in the number of patient-days provided during 1939 as compared with 1936 in 17 of the 18 areas. Twelve of the areas showed increases in excess of 10 percent and in 3 of these, Grand Rapids, Dayton, and Akron, the increases were greater than 20 percent.

Published under authority of Public Resolution No. 57, approved May 11, 1922 (42 Stat. 541), as amended by section 307 Public Act 212, approved June 30, 1932 (47 Stat. 409). This publication approved by the Director, Bureau of the Budget, May 12, 1936.

U S GOVERNMENT PRINTING OFFICE 1940 — O - 277201

The CHILD

Monthly Bulletin

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Home-Saving Through Housekeeper Service

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Child-Labor Standards and Defense Contracts

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

OCTOBER 1940

THE CHILD

MONTHLY BULLETIN

Volume 5, Number 4 October 1940

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• BIRTH •
• GROWTH •
• CHILD HEALTH •

Conservation of the Medically Handicapped Child

By Julian D. Boyd, M. D.

Department of Pediatrics, State University of Iowa, Iowa City

THE SIGHT or even the thought of a child who is unable to run and play is sure to strike a responsive note of sympathy. There are other children, however, who are as badly handicapped by disease and whose needs are fully as great who have failed to receive as widespread attention because their disabilities are not apparent to the observer. It is important that consideration be given to all children with handicaps due to disease or to deformity.

The pediatrist's interests are directed toward the child as a whole rather than toward his physical disability. The child specialist's work brings him into contact chiefly with children whose handicaps may be termed medical rather than physical—children with chronic disease that directly or indirectly interferes with their normal participation in life. The same considerations, however, will apply basically to all children with chronic physical disability.

If all illnesses were acute, self-limited processes, problems of care would be simplified greatly. During the time of the child's acute illness his obvious disability makes his need for care apparent to all and effort is made to protect him. Even though such illness may precipitate an economic crisis in the home, the emergency usually will be met in one way or another. If the child makes a complete recovery, he usually will soon catch up on the school work he missed. Unfortunately, many relatively minor illnesses project unfavorable effects on the body for weeks or even months after convalescence apparently is complete. In making his adjustment to normal surroundings the patient carries a residual physical handicap of varying degree. When circumstances lead to a shortening of the period of convalescent care or to lessened attention during the period of acute illness, this handicap is heightened; with chronic illness, the problem is much more complex.

Chronic illnesses differ widely in their nature, cause, and residual effect on the patient. Some diseases appear insidiously and may have been operative for weeks or even for years before their existence is suspected. The child with tuberculous infection usually offers no physical evidence of disease until months or years have elapsed. The child born of syphilitic parents may appear free from disease until midchildhood, when the development of severe damage to the eyes, the central nervous system, or other area leads to recognition of his infected state. In the two diseases just cited the continuance of infection over periods of years is the rule, even with early recognition and adequate treatment. If his vital organs have been damaged the patient often carries his infirmity throughout life, even though the causative disease has been cured or arrested.

Heart disease, secondary to rheumatic infection, serves as another excellent example of the persistence of disability. Damage to the heart arises as a complication of a rheumatic infection which usually in itself is rather mild in its manifestations. The patient may even make an apparent recovery without the heart damage having been recognized. The damage to the heart lessens the functional capacity of the circulatory system, and when the body calls on the heart for greater service than it is capable of performing symptoms of heart failure become apparent. If the child is nursed carefully through his active disease and his protracted period of convalescence there is strong likelihood that part of the damage will be relieved and that his heart will become strengthened sufficiently to perform under reasonable demands in a fairly satisfactory manner. Such a child, however, usually will carry some degree of heart disability for years, if not for life, and should receive suitable safeguards against further disability. If his physical activities can be kept within the capacity of his heart, his handicap will not be apparent. If, on the other hand, he tries to live the life of the normally active child, chronic heart failure may become established and the child remain incapacitated or die at an early age.

Diabetes mellitus represents another type of chronic illness that may lead abruptly to death or more insidiously to degenerative changes in the body tissues. With suitable treatment the disease can be kept under control, permitting the patient to lead essentially a wholesome and enjoyable life, free from outward evidence of his abnormality. Without treatment, the disease as it occurs in the child is almost invariably fatal within a few months. The condition is not curable; at times of other illness or when extra demands are made on the body for any other reason, the severity of the metabolic defect is increased and serious complications become imminent.

If arrangements cannot be made for the maintenance of the necessary regimen, the patient may become critically ill within a period of a few days and succumb, even though his management hitherto has been ideal. His whole manner of living must be designed to permit such a regimen, and the patient must recognize that his disability will persist throughout life. The reward of proper management is radiant health with no evidence of his disability apparent to his associates.

In review, it is apparent that the ultimate outlook for the child with chronic illness will be influenced by numerous factors, many of which are not medical in nature. Of the medical or physical components, the nature of the disease may be the determinant. Some diseases may become completely inactive, leaving eventually an unpredictable degree of damage to vital body functions; here the medical outlook will be based on the degree of disability of the vital function, the ability of the patient to strike a balance between his degree of disability and the demands of his environment, and his opportunity to remain satisfactorily under such a limited regimen. Other diseases, such as childhood tuberculosis, tend to remain quiescent as long as the patient can lead a life free from deprivation, with assurance of measures which will lead to health advancement and avoidance of contact with sources of further contagion. Such an individual need not be limited in his opportunities for social intercourse or for development. Some other diseases, such as diabetes mellitus, lead to a permanent physical disability which can be controlled wholly as long as a stringent regimen of life and of treatment is maintained, but if such treatment is not available it is predictable that complications will arise which eventually will lead to incapacity or to death.

The outlook for the child with chronic illness is determined not only by the type and amount of medical supervision he receives during and after his episodes of acute illness but also by the adequacy of his environment to meet his needs. These needs include both those demanded because of his illness in itself and those which are necessary even for the normal healthy child if he is to be safeguarded against the threat of disability. Even though the child receive the best of medical and nursing care through his period of illness and during convalescence and even later, certain handicaps will arise to limit his future activities, unless specific measures are directed toward them.

Childhood is the period of preparation for adult life. During that time the child must learn to take his place in the world as an independent, adequate, self-supporting individual. He must receive a basic education and in addition must learn to apply this in a practical manner if he is to avoid a state of dependency as an adult. He must learn to be economically and socially self-sufficient and in addition must be led toward emotional maturity. As a rule these important phases of the child's welfare are neglected when chronic illness is present, and the ultimate handicap from these factors is as great as or even greater in some instances than the medical condition. The individual who has an affliction which in itself would permit fair or even full participation in the activities of life may become permanently displaced from the position he could fill because of social, educational, or emotional obstacles. It is true that many of our adult citizens are handicapped in these regards even though they never have experienced chronic illness, but this should not lessen the concern of those who care for the child who is ill. Many children with chronic physical disabilities can look forward to a life of incapacity and dependence, on the one hand, or to one of participation and of self-sufficiency, on the other, the outcome to be determined by the opportunities which the child is offered during the course of his illness and through his subsequent childhood.

From the viewpoint of the medical scientist it is important to prevent disease and to treat it in such a manner that it is terminated as soon as possible with a minimum of residual damage. With diseases which necessarily are protracted or incurable it is desirable to establish and maintain a regimen of management which will conserve the patient's health to the utmost degree and allow him to lead as normal a type of life as his handicap will permit. The level of medical care attained will depend on several factors. Some diseases can be treated adequately with the medical facilities available through the services of the general practitioner in the patient's home. Other diseases through their nature demand that the services of the specialist be employed either as the consultant or as the director of medical management.

Without exception the child with chronic illness needs medical supervision which extends beyond the acute episodes of his disease; he should be seen regularly by the physician so that a program of health advancement, conservation, and early recognition of complications may be maintained. The nature of certain illnesses makes it important, if not obligatory, that the child be placed in a well-equipped hospital for certain phases of his treatment. Frequently the detailed nursing service required by the sick child makes a greater demand than the average household is able to meet. In other instances the physical, economic, or emotional state in the home makes it desirable that the child be treated elsewhere, if his best interests are to be conserved.

During protracted convalescence it is often preferable for the child to remain either in a convalescent nursing home or in a supervised foster home rather than for him to stay in the environment which contributed to the development of his disease. The physician cannot meet all these problems of medical care singlehanded.

Economic factors frequently stand in the way of desirable care, and although these might be met if the illness were self-limited in its nature, the continued drain over periods of weeks, with the prospect of its continuance for months or even years, can lead to the impoverishment of the family which ordinarily would be self-sufficient.

Emotional factors are equally potent in the encouragement of a compromise. The parents or other members of the household may not be willing to subordinate their own interests in the child's company to his ultimate good. Once the child recovers from the outward evidences of his illness it becomes progressively more difficult for the physician to maintain the regimen which he may recognize is necessary for the best interests of the patient. As a result the type of medical treatment which the chronically ill child receives is a compromise between the measures he needs and the level of management which is convenient for his attendants to administer. There is the tendency for treatment to be passive in nature, barely aggressive enough to avoid catastrophe, leading often toward greater disability rather than less. The physician should not be criticized if he fails to insist on measures of treatment which may seem unnecessary to the parent, which call for a prolongation of medical supervision of the patient, or which are beyond the ability of the family to pay for. All these factors conspire to perpetuate the passive methods of therapy and similarly to perpetuate the patient's disability. When all in the community can come to cooperate in attaining the maximum level of medical service and when resources can be made available by public agencies to care for those unable to pay for the necessary care, this phase of salvage can become increasingly effective.

Medical phases of treatment should not be considered to the exclusion of other factors necessary for salvage. There is a tendency to credit all of the child's disability to his illness, to his physical crippling, or to other medical handicaps. This is a fair assumption in some conditions, yet in all instances the patient's residual handicaps include social, educational, and emotional inadequacies or maladjustment. Frequently these outweigh the physical incapacity as a cause of enforced invalidism.

During his illness the child is torn from his previous contacts. He becomes as dependent on his environment as an infant. Sometimes pain and suffering are components of the new world in which he finds himself. Prolongation of such a status serves to widen the gap between the child who was well and the child who is ill. After such experiences it is not easy for the child to return to his previous habits of independence and of activity even though his recovery from illness is complete and permanent. It becomes necessary for him to make new associates or rediscover his old ones. Often he loses out on his school work so that he must join the ranks of younger children. Loss of interest or the continued regimen of medical care makes it easy for him to discontinue his schooling. Failures and frustrations mold his outlook, readily leading to the establishment of a sense of defeat.

His handicap may be relatively minor, yet circumstances lead to its exaggeration because of the failure of his attendants to utilize measures for salvage during illness and convalescence. When such a child reaches adulthood he has little chance to overcome the disabilities induced through his medical condition, his unfamiliarity with a vocation, his defeatism, and frequently his precarious economic status. Even with a good capacity for normal physical activities, his situation is not one which is favorable toward the establishment of the usual pattern of adult life. The situation surely is ironic, when medical treatment permits the continuation of life, yet socioeconomic forces prevent normal participation in its activities.

Obviously the regimen of treatment of the child with chronic illness should be designed to assure a minimal degree of physical handicap and the maximum salvage or development of the child's social capacities. Other agencies must operate in teamwork with the physician if the objectives of the plan for salvage are to be realized. Yet how often are these other agencies made a part of the plan of treatment for the handicapped child? The usual procedure is to deal passively with the situation, accepting the child's ultimate state as inevitable. Even the exceptional child seldom receives the special attention he warrants; in most instances the salvage potentialities are not even considered.

A satisfactory program for the discovery and treatment of chronic illness in children would begin with the routine physical examination of well children by pediatrists so that disease could be recognized in its incipiency. Next, the ideal program would include an appraisal of the child's environment, as to the manner in which it has contributed to the child's unfavorable status and as to the likelihood of correction of undesirable conditions. Third, it would provide a plan for supervision of the child's welfare until the disease had been cured or the patient had achieved his maximum recovery. Fourth, it would aid in the attainment of optimum facilities for treatment of the child during active illness and subsequently during convalescence. Last, it would offer an interpretation of the child's needs, capabilities, and ultimate outlook to the parents and the nonmedical agencies concerned with childhood, so that they could work toward a plan for living which would be within the child's capacity.

The foregoing plan admittedly is idealistic, but it is not beyond reason or attainment. It does not call for a quality of medical attention different from that generally available; it calls primarily for a breadth of vision and an integration of the work of agencies concerned with the child. However, it places upon the physician the burden of initiative and interpretation.

When the child is obviously ill, all agencies and individuals look to the medical attendant for direction, and other activities are subordinated to the management of the illness. If the physician confines his thought and attention to the strictly medical phases of treatment of the current illness, treatment may lapse during the subsequent phases of the disease and the patient lose all the ground he previously has gained. If the physician fails to make the parents and the educators partners in planning the child's subsequent activities, either the child's training may be neglected or the encouragement of overactivity may lead to irreparable damage to his physique. Once the spectacular phases of the disease have run their course or have become accepted by the parents and the patient, it frequently is difficult for the physician to maintain the requisite level of care. All factors conspire to encourage a fatalistic attitude toward the patient's disease, with the result that the ultimate outcome depends more on the patient's inherent capacity for health than on the nature of the therapeutic regimen.

The best results will be realized only when the physician and parents work actively on a program of betterment of conditions and do not merely attempt to stem the tide of the disease. If the problem of salvage is kept in mind at all times, much can be accomplished for the habilitation of the child with chronic illness, even under the most adverse conditions.

During periods of protracted convalescence, when the activity of the child's mind calls for something to occupy his attention, his program of recreation can be adapted to his educational capacity and needs.

In favored areas of this country the public-school system cooperates in the activities of some of these children. When the patient's participation in school work is made impossible because of physical limitations, special arrangements are made to lessen the demands for physical exertion or to permit schooling through the visiting teacher, through radio connection with the classroom, or by other means. It is even more important for a child who will carry a handicap of physique or of disease throughout life to be assured of the means for meeting life's problems than it is for the child who is fortunate enough to have high physical capabilities. With adequate training many of our medically handicapped children can become partly or entirely independent. Without it and in the absence of special ability it may be predicted that they will become charges on their relatives or on the community.

The skilled social worker, the public-health nurse, the visiting teacher, and the child psychologist can assist the physician in the integration of the child's care so as to meet his needs in their entirety. Unfortunately many areas do not have such skilled workers available, or the local needs are such that the activities of the experts are fully occupied meeting problems of emergency relief. In such a situation constructive activities often are overlooked.

Comparison of the facilities necessary for proper care of the child with chronic illness with those which are generally available will give a concept of the extent of the problem.

In summary the chief needs for an adequate program pertain to the provision of skilled personnel, physical equipment, integration of facilities already available, and the development of a positive philosophy of attack. Cooperative effort of the whole community and the State is essential to the best results in the care of the handicapped child. Medical service of acceptable nature is usually attainable through some means or other if provision is made for meeting the cost and if resources are known. Hospital care and the cost of medical care must be provided from voluntary contributions or from public funds; also the services of workers especially trained to meet the child's needs—the social worker, the public-health nurse, the nutritionist, and the visiting teacher.

We have a long way to go before effective measures for safeguarding the child with chronic illness can become universally available. Until that time comes, human life and efficiency will continue to be squandered. While this problem of salvage is being attacked, other avenues of study are being directed toward means for prevention of these diseases. As our awareness increases, we come to recognize that much of the misfortune which often is considered inevitable is merely a reflection of the passive, fatalistic attitude of human nature.

The Family Physician Cooperates With the Health Department

By T. R. Meyer, M. D., Dr. P. H.

St. Louis County (Mo.) Health Commissioner

Countless persons reflect the attitudes of their family physician in their ideas and conclusions on public-health matters. Every physician to whom his patients look for advice on matters of health thus becomes a protector of public health and an educator of the public. It is the aim of the St. Louis County Health Department to utilize in our public-health program the family physician and the respect that he rightfully commands.

The success of any examination of small children is dependent on the presence of the parent in order that the physician may discuss with the parent the findings of the medical examination and the corrective procedures recommended. This has not been successfully carried out in most school health programs.

For the most part school physical examinations have been casual, superficial once-overs of children run like an endless belt or conveyor past the school physician. If the parents are not present, as usually is the case, a notification is sent advising Mrs. Smith "that Robert was examined this day by the school physician; that the defects marked with a cross were found; and that Robert be sent to the family physician for correction of these defects."

The results of the stereotyped school examination programs have been poor. A review of the statistics reveals that only 3 or 4 percent of the defects recorded are corrected by this procedure; this means that if the children from one year's third grade were reexamined in the fourth grade the next year, about 95 percent of the same old defects would be found, plus some new ones.

Moreover, when parents in the conscientious 3 or 4 percent go to the family physician as a result of the examination and tell the man who got up one cold December morning to bring Robert into the world (and probably knows better than any one else Robert's physical make-up) that the school physician says Robert should have his tonsils removed no wonder the family physician "blows up!" If he points out that Robert's general condition in his opinion does not indicate a tonsillectomy at this particular time, confusion results; and confusion does not enhance the respect of the public for the medical profession.

During the past 3 years the St. Louis County Health Department, in cooperation with the Medical Society of St. Louis County, has taken an entirely new approach in the handling of physical examinations of school children. The plan was suggested by the health department and endorsed by the medical society and has been carried out in 1937, 1938, and 1939.

The first step was to change the term "physical examination" to "medical examination." Many persons, including nurses and physical-education teachers, may be capable of making what they might term a "physical examination." Only physicians (M. D.'s) are eligible to make a medical examination.

The second step was to transfer the examinations from the school to the family physician's office. There are various reasons for this, the chief one being that young children cannot go alone to the physician's office but must be accompanied by their parents.

Through the cooperation of the Medical Society of St. Louis County 143 physicians have agreed to make medical examinations of entering school children in their offices at designated hours.

St. Louis County, with its approximate 500 square miles, includes not only several cities but territory as rural as the Ozarks. In the urban schools examinations are offered to children entering kindergarten, but in rural schools that do not have kindergartens children entering the first grade are examined. In this paper "entering school children" include children in kindergarten and in the first grade who have not attended school before.

The question of how often a school child should be examined is now under consideration, and it is hoped that present facilities for examination of entering school children can be extended to children in a higher grade, possibly the fifth, and to children entering high school.

A list of the participating physicians with their addresses and their office hours for examinations of school children is supplied to parents.

All the family physicians participating in the plan give medical examinations to entering school children without charge, regardless of the family's ability to pay. The child presents an identification card with a medical-examination certificate on the reverse to be signed by the physician.

The medical-examination blanks, with which each participating physician is supplied in duplicate by the health department, are made up simply and inexpensively in mimeographed form. The copy to be returned to the health department may be mailed in or handed in by the physicians, of whom some are on the staff of the county hospital and some come to the hospital to use the laboratory services. The remainder of the certificates are collected by the district nurse periodically.

Payment for corrective work is made to the family physician by parents who are able to pay. If the physician believes the parents unable to pay he has the prerogative of referring the case to the health department, which arranges with the county hospital for necessary corrective medical or surgical care. In this connection the commissioner of hospitals of St. Louis County has made the services of the hospital social-service staff available, and they have worked out jointly with the health commissioner and his staff forms and blanks to be filled out by the family physician for all applicants for hospital care.

Results of the St. Louis County program, as indicated in the first 3 years of operation, are:

1. Education of parents to take their children to a physician's office and to establish early in their children's lives the habit of seeking medical supervision.
2. Correction of physical defects in an increasingly high percentage of cases.

In one group of 709 entering school children who were examined last year by private family physicians in their own offices the results are rather striking: 644 parents, approximately 91 percent, were in attendance at the examinations. The only defects recorded for this group of children studied were those of a serious nature. Of the 278 serious defects found among these 709 children, 183—a total of 66 percent—were corrected: 44 percent of defects of tonsils and adenoids; 89 percent of dental defects; 72 percent of visual defects; 97 percent of skin defects; 66 percent of nutrition defects; 38 percent of hernias: and 40 percent of orthopedic defects.

Negotiations are under way with the Dental Society of St. Louis County to extend a program to school children through the family dentist's office similar to that which has been so satisfactorily worked out with the medical profession.

The same principle of medical participation of the family physician is utilized in every other phase of our local health program. In other words, a program of medical participation is applicable to contagious disease, tuberculosis, venereal disease, and particularly to maternity hygiene.

Prenatal and postnatal supervision is given through the maternity clinic to all women who are unable to pay for the services of a private physician. A medical social worker on the hospital staff determines eligibility for clinic services and begins a clinical history, which is used in the maternity and all other hospital clinics in order to give a complete picture of the patient's physical condition. The combined opinion of the family physician and the clinicians of the maternity clinic determines whether a patient is to be referred to the county hospital for delivery or delivered at home by the family physician. All normal multiparas whose homes are adequate for a home delivery are referred directly back to the family physicians of their choice for delivery services and postpartum care. If the family physician wishes to do so he may refer his patients back to the maternity clinic for postpartum examinations and any necessary follow-up care. The health department has worked out with the county medical society a plan for a fixed financial contribution to the family physician toward his fee for home deliveries in this program. During the years 1938 and 1939 under this combined arrangement of home and hospital deliveries 1,218 deliveries were made without a single maternal death.

Incidentally, a clinic for expectant fathers has recently been added to the health-department activities. Each registrant receives a physical examination and a serological test for syphilis.

On the basis of our experience with health programs in which the family physician participates we are convinced that the organized medical profession can make a material contribution to the improvement of public health. We have found that our program of medical participation in public-health work is beneficial to the public, the physician, and the health department.

BOOK NOTES

Recent publications in the health field Among recent reports and publications in the field of public health the following have been received:

Advances in New York City's Health. Annual Report of the Department of Health of the City of New York for 1939 with a review of developments from 1934 to 1939. (New York, October 1940. 296 pp.) During the 6 years of progress summarized in the opening section "infant mortality rates attained new lows, decreasing steadily from 53 per 1,000 live births in 1933 to 37 per 1,000 live births in 1939. The puerperal death rate decreased from 6 per 1,000 terminated pregnancies in 1933 to 3 per 1,000 terminated pregnancies in 1939. In this period the lowest general death rate in the city was recorded. . . . Diphtheria deaths decreased from 86 in 1933 to 22 in 1939."

Healthful Living Through the School Day and in Home and Community (State Department of Public Health, Santa Fe, N. Mex., September 1940. 103 pp.). This is a revised edition of Healthful Living Series, Bulletin No. 1, prepared for the use of teachers in New Mexico.

A Tuberculin Testing Program in a School System of About 10,000 Pupils, by W. N. Braley, M. D., Health Officer. (City of Highland Park, Mich. Processed.) Methods of public education included a poster used by theaters, a steady stream of newspaper publicity, and a radio discussion of the value of tuberculin testing, all of which are given full presentation in this report.

Manual for the Conduct of Classes for Expectant Parents. (Cleveland Child Health Association, Cleveland, December 1939. 137 pp. $1.)

Educational Programs for Expectant Parents; analysis of replies to a questionnaire survey. (Cleveland Child Health Association, October 1939. 73 pp. 50 cents.)

Recent bibliographies The library of the United States Department of Labor has compiled a mimeographed list of selected recent references on The National Health Program and Medical Care in the United States (Washington, June 1940. 25 pp.).

A Selective List of Periodicals of General Interest Published in Latin America, 1940, has been compiled by the Division of Intellectual Cooperation of the Pan American Union (Washington, 1940, 30 pp. Mimeographed.). Periodicals published in Spanish, Portuguese, and French are included, with an indication as to the type, policy, and quality of each.

* * * * *

FETAL AND NEONATAL DEATH, by Edith L. Potter, M. D., and Fred L. Adair, M. D. University of Chicago Press, Chicago, 1940. 207 pp. $1.50.

The need has long been felt for a manual of pathology dealing with the fetal and neonatal period. This book, in addition to dealing with techniques and interpretation of special pathology, contains a chapter on trends of births, stillbirths, and neonatal deaths for the United States and tables showing the causes of fetal and neonatal deaths determined in the course of pathologic studies made in the Chicago Lying-in Hospital by the authors, as well as the findings of other investigators in this field. Bibliographical references follow each chapter.

An unusual contribution is the second chapter (57 pp.) on the normal fetus and infant with a detailed discussion of organ structure and development during fetal life. The third chapter describes the methods of postmortem examination with emphasis on the importance of using a technique that will give "the best exposure of the structures to be inspected," and on the need for a complete examination and for keeping accurate records of findings. Several diagrams and photographs illustrate important points in this section.

In the fourth chapter the chief causes of fetal and neonatal death are discussed from the etiological standpoint with reference to data from medical literature as well as to the authors' material. Special pathology is taken up in chapter five on an anatomical basis with emphasis on the lesions of the central nervous and cardiovascular systems. A page of diagrams demonstrates clearly some of the commoner disturbances of circulation due to persistence of fetal circulation or to defects in the heart or vessels.

This handbook should prove valuable to physicians, especially obstetricians and pediatricians, and, of course, pathologists and should stimulate more careful and complete postmortem study of stillborn infants and infants who die in the neonatal period.

E. C. D.

The Public Health Nurse and Her Patient, by Ruth Gilbert. Commonwealth Fund, New York, 1940. 396 pp. $2.25.

This book, written by a public-health nurse who is also a psychiatric social worker, deals with the integration of mental hygiene with public-health nursing.

Public-health nursing is broadly interpreted to mean "not only the actual services of the nurse in the field but other relationships and activities of her professional life such as the planning of her work, supervisory relationships, and relationships with other workers—all of which merge in the long run in service to the individual and the family. Administration and program as well as performance sum up public-health nursing."

Mental hygiene is considered not so much as an additional type of service and function of public-health nursing as an enrichment of the quality of public-health-nursing services through greater understanding by the public-health nurse of the attitudes, relationships, and behavior of the nurse herself, of the recipients of her services, and of her co-workers in and outside of the public-health-nursing agency.

Nearly one-third of the text pages are concerned with the maternity patient and with the child. The chapter on the Nurse and Maternity Patient is designed to make the nurse aware of the emotional reactions to pregnancy encountered in women under varying circumstances and at each period of pregnancy.

In the chapter, The Child in His Family, without repetition of basic material on child care and development which is readily available elsewhere, the author suggests some of the points at which developmental research may be applicable to child-health supervision by the public-health nurse under medical guidance. She discusses the relationship between the child's maturation, his developing abilities and skills, and certain phases of personality development and behavior, such as self-assertiveness, destructiveness, thumbsucking, and learning to talk; many familiar training situations; and, briefly, problem behavior.

Subject index and bibliography are appended.

H. H.

Public Health Nursing in Obstetrics, Part I. Maternity Center Association, New York, 1940. 83 pp. 50 cents.

The Maternity Center Association of New York plans to publish three booklets under the title, "Public Health Nursing in Obstetrics." Part I, which has recently appeared, brings together in an easily available form information which should be of value to the public-health nurse. The facilities for obstetric care in the United States are summarized briefly in the first section, with pictographs showing that, where good obstetric care is available, some maternal deaths are prevented. Terms commonly used in obstetrics are defined and discussed in the second section.

What constitutes good obstetric care is discussed in the third section. Here, good obstetric care is used in its broadest meaning as including "marriage counseling—instruction, counsel, and health promotion, before and after marriage, to help men and women make a success of marriage for their own and their children's sakes." In addition, all the components that constitute safe care throughout the maternity cycle are outlined.

The fourth section, The Local Situation, covers half of the book and is devoted largely to forms and questionnaires designed to give a complete picture of all factors in the care of mothers and newborn infants in a community.

N. D.

Food for Health in Peace and War. Canadian Medical Association, 184 College Street, Toronto, 1940. 19 pp.

What Canadian doctors suggest for wholesome meals at low cost is outlined in this pamphlet, which is receiving wide distribution to families throughout Canada. The Canadian Dietetic Association assisted in the preparation of the food lists, which were tested by Canadian families under the supervision of the Visiting Homemakers Association.

The Children's Bureau *does not distribute* the publications to which reference is made in THE CHILD except those issued by the Bureau itself. Please write to the publisher or agency mentioned for all others.

• CHILD WELFARE •
• SOCIAL SERVICES •
• CHILD GUIDANCE •

Home-Saving Through Housekeeper Service

By Juanita Venrick Perkins

Colorado State Department of Public Welfare, Denver, Colo.

"I want to keep my girls with me, but I just can't do it. I certainly have tried, but I guess I'm beaten." Mr. Edstrom spoke despairingty to the child-welfare worker as soon as he had been introduced to her by the public-welfare director of the county.

"Do not say that you are beaten. Sit down and we will talk the situation over together," the child-welfare worker suggested with a smile.

Mr. Edstrom seated himself across the desk from her and then continued. "You see, ma'am, their mother is dead; she died 2 years ago of pneumonia, following an operation. I was working as a salesman at that time and my salary and commission averaged around $200 a month. There were large hospital bills, doctor's bills—the funeral took just about all we had saved. Then, last year," and he smiled wryly, "I lost my job."

"Are you working now?" the child-welfare worker asked.

"Yes, I'm working on WPA, and have been for the last 8 months. I'm certainly glad to have it, too. I was just desperate for a job before I got this. I wanted to make enough to take care of my three girls and to hire a housekeeper to look after them, but it's no use."

"What do you mean when you say, 'It's no use'?"

"I've paid as much as $50 a month for a housekeeper and as little as $15, but it doesn't make any difference; I haven't been able to find one who thinks of anything or anyone but herself," he explained. "We're without a housekeeper now and instead of trying to get another one, I thought perhaps I'd talk to you about one of the boarding homes I'm told you have. I know I can't pay room and board for all three of the girls and keep myself, too, but I thought maybe you could suggest something."

"You say you have three girls; how old are they?"

"Lela is 11, Mildred is 9, and Mae is 6. They are healthy and nice, too, if I do say so myself. I wish their mother could see them." His voice broke.

The worker, sensing the strong tie between the father and children and realizing the value of keeping this family unit together, said: "Perhaps I could find a mother who would come into your home and would supervise your girls just as she would supervise her own children. Would you like that?"

"No, ma'am, I just couldn't endure seeing anyone assume their mother's place in my home. It would be different if they were in a boarding home; I couldn't see it then." He hesitated—"You see, I promised my wife that I would be both a mother and a father to the girls and that's what I intend to be," and a defiant light gleamed in his eyes. "All I expect of a housekeeper is someone to look after the children when I'm working, to keep the house clean, and to prepare the meals."

Here was an average father—fearful and apprehensive lest a woman entering his home act as a mother substitute to his girls. The worker talked to him at length of the part the mother and father each play in family life and of the difficulties parents encounter even in normal homes when both parents assume their respective duties. When it is necessary for one parent to assume the dual role, it is even more difficult.

The responsibilities of the housekeeper were listed as covering matters of household management but the sharing with the father in the training and guidance of the children was stressed as being of even more importance. It was emphasized that the training of Mildred and Mae should include instructions in household tasks and in personal cleanliness. Because Lela is older, the housekeeper should assume the role of teacher, training her to assume, eventually, the entire responsibility of the home.

It was further pointed out that the father would be in partnership with the child-welfare worker and that he and she, with the housekeeper, would plan together for the family. In this connection, there was a discussion of time off for the housekeeper. It was decided that one afternoon during the week in addition to each Sunday afternoon would be satisfactory. This would enable the housekeeper to have a life independent of the Edstrom family.

"If I decide to try this, where can you get a woman such as you have described?" Mr. Edstrom asked doubtfully.

"I have several in mind," the child-welfare worker said, and then an understanding smile crossed her lips. "I see you are wondering about it, I'll explain. The child-welfare worker studies a prospective housekeeper as carefully as she does a prospective foster home. After the study is completed, she submits her recommendation, with the study, to the State director of child welfare for final approval or disapproval. If approval is given, the housekeeper is notified that she has been accepted. Before we consider a housekeeper for this position, however, I think we should first consult your daughters to see if they will accept or resent a woman coming into the home to be like a mother to them."

"That's been one of the troubles," replied Mr. Edstrom. "Lela complained that the women never did things in the manner that their mother did them and no matter how hard some of them tried it was never right."

The child-welfare worker explained that it was his job to interpret the housekeeper to the children and to explain her responsibilities to them and theirs to her. It was emphasized that it is only natural that children have a feeling that the home is theirs and they do not need to obey a stranger in it.

"A woman such as you describe would expect more than $15 a month and that's all I can possibly pay. To tell you the truth, $15 is a great deal more than I can afford." Mr. Edstrom spoke in a matter-of-fact tone.

A budget was prepared and Mr. Edstrom's monthly income, expenses, and debts were listed. It was shown that he would not be able to contribute anything toward a housekeeper's wages without depriving the children and himself of the bare necessities. The child-welfare worker explained that if, after talking to the children, it was decided to try this plan, the Child Welfare Division could use its money to keep a home together by placing a housekeeper in it, as well as to pay board for children outside their own homes.

This was a new idea to Mr. Edstrom. After it had been fully explained to him he was eager that she visit his home, meet his daughters, and endeavor to arrange for a housekeeper.

A visit to the home revealed that the Edstroms had the minimum equipment in household utensils and supplies. There was an enclosed sleeping porch, which could be converted into a bedroom, thus giving the housekeeper privacy and affording the family an opportunity to be alone. Heretofore the "hired woman" had slept on a cot in the kitchen or on the davenport in the living room. The five-room bungalow with sleeping porch was comfortably furnished but ill-kept.

Mrs. Brown was the housekeeper selected as the one who was best equipped to do the job. The child-welfare worker explained the situation to her and prepared her in the same manner as she had prepared the father and children for the roles they would be required to assume. The practical details involving the planning of adequate and wholesome meals on a very limited budget and of keeping house with less equipment than that to which she had been accustomed, were thoroughly discussed. It was further explained that the child-welfare worker did not expect her to become adept in handling all the problems at once, but a realization of factors and a willingness to ask assistance with problems as they might arise, would be expected. If the children manifested signs of hostility, she was cautioned to be very tolerant, inasmuch as the antagonism, in all probability, would not be directed toward her personally. The housekeeper indicated she would be willing and able to take supervision from the child-welfare worker. Arrangements were made for her to meet the father at the office of the child-welfare worker and to discuss matters with him. The child-welfare worker emphasized that the father was a partner in this plan and even though the Child Welfare Division would be paying her for her service, this was his home and he its rightful head.

The child-welfare worker saw the father in her office and described Mrs. Brown to him as a widow in her late fifties who had successfully reared two daughters. They are now married and have children of their own. All members of these families are delighted to have Mrs. Brown visit them. She, therefore, spends as much time as possible in their homes. The child-welfare worker had been in one of the homes during the absence of the parents and she had observed Mrs. Brown handling her grandchildren in a calm, well-balanced manner when discipline was necessary. The child-welfare worker further observed that Mrs. Brown was free from worry; therefore, it was felt that her full attention could be devoted to the Edstrom family. Since her husband's death 5 years before, Mrs. Brown had served as housekeeper in two homes. Both families highly recommended Mrs. Brown as a woman of pleasing personality who got along well with children and was a good cook. The child-welfare worker pointed out to Mr. Edstrom the fact that Mrs. Brown was 15 years older than he, and this would make the situation more acceptable to him and the girls—the housekeeper would not be a rival for the mother's place.

When the father interviewed Mrs. Brown later, she was accepted, and the three-cornered plan, which had been so carefully devised by the father, the housekeeper, and the child-welfare worker, was put into operation.

Mrs. Brown has been in the Edstrom home for 4 months and, during this time, some difficulties have arisen which, in all instances, have been solved through conferences of the father, the housekeeper, and the child-welfare worker. Mrs. Brown has been invited to join the parent-teacher association and is already active in the home-demonstration club of the community.

On the 14th of June Lela sat with the eighth-grade graduating class beautifully dressed in white organdie. As soon as the last diploma had been presented, Mr. Edstrom sought the child-welfare worker, who was talking with Lela's teacher. With eyes glistening with pride and a voice filled with emotion, he said: "Doesn't Lela look lovely? Mrs. Brown made her dress—I was afraid to hope that our plan would work out—but it certainly has." He started away, then came back.

"There's another man working with me who is going through the same thing I was when I met you. May I bring him into your office next week?"

To this story, which appeared in the quarterly publication of the Colorado State Department of Public Welfare for April–June 1938 under the title "Their Own Home," a sequel can now be added:

Mrs. Brown remained in the Edstrom home for 1 year. During this time she trained the three girls in desirable home duties and personal habits in keeping with their age. With Lela, the oldest, she assumed the role of teacher, training her to take over eventually the entire responsibility of the house. However, the father's remarriage in 1939 made it unnecessary for Lela to assume this responsibility.

In evaluating the year of housekeeper service afforded this family, the father and the child-welfare worker mutually concluded that such service had (1) made it possible for him to continue to maintain a home for his girls so that family ties between father and children could be preserved; (2) enabled Lela to finish the eighth grade; (3) provided much-needed training and a "mother's influence" during their early adolescent years; (4) prepared them well for adjustment to their stepmother.

Housekeeper service has been used frequently under the program of Colorado child-welfare services to keep family units together where for one reason or another, either temporarily or permanently, the mother is unable to assume the responsibility in the home. The following four classifications represent the kinds of situations in which housekeeper service has seemed most useful.

The first group includes families in which the mother is permanently out of the home, either through death as in the Edstrom case or through institutionalization. If the father in such cases is closely tied to the children and the background of the family is as stable as the average, housekeeper service has proved most satisfactory.

The second group includes families in which the mother is out of the home for an indefinite period—in a tuberculosis sanatorium, say—but with a hope of returning some time in the future. Here a slightly different element enters into the plans, as not only must the family unit be preserved but the home must be prepared for the ultimate return of the mother.

A third group is formed by families in which the mother is in the home but permanently an invalid. Here the attitude of the mother is the vital and deciding factor in the situation.

The fourth group comprises the families in which the mother is temporarily out of the home or temporarily unable to assume the responsibility if in the home. This last group represents the least urgent claim for housekeeper service, and in some instances maid service has been utilized successfully.

Under these four classifications the Division of Child Welfare has employed 17 housekeepers in 18 families during the last 2 years. The length of employment in any one family ranges from a temporary placement of 1 month to permanent placements of 2 years in which employment will be continued until the oldest girl can assume responsibility or there is some other change in family relationships making housekeeper service unnecessary. Housekeepers who prove satisfactory after the first probationary placement are moved from one family to another wherever the need exists. By selecting women who are free to move into new communities the agency is able to assure permanent employment to a certain number of women and to build up a register of capable housekeepers.

Although housekeeper service has been used in seven rural counties in Colorado, most of the housekeeper-service program is concentrated, as it should be, in counties that have a full-time child-welfare worker with professional training. For in some ways the case worker's role in housekeeper service is the most difficult in this three-cornered arrangement between the father, the housekeeper, and the case worker. Knowing more about the working out of such arrangements and not being involved emotionally in the situation, she has the responsibility of helping the others to see their individual problems and how they are interwoven.

Recruiting housekeepers has proved a difficult task in rural communities. For it is the unusual person who has any conception of a housekeeper other than as a dependable "hired woman." So in each county it has meant a careful differentiation between the types of responsibility involved in being a maid and in being a homemaker. It has also meant that the child-welfare workers have been swamped with referrals and applications of women who are laid off of work programs periodically and see this housekeeper program of child-welfare services as another work project.

It has proved helpful to explain to county welfare staffs, advisory boards, and service groups some of the difficulties the child-welfare worker incurs in the selection of a person capable of filling the position of homemaker in a motherless home. Many women seeking a housekeeper's position may be motivated by the need for a job and a natural love for children without recognizing the emotional factors involved in the acceptance by any family of someone to take the mother's place in the home.

Although there has been some need for housekeepers for day service as well as for those who live in the home, it has been difficult to work out day service in rural areas in this State where distances are great and means of transportation scarce for individual rural families.

In the 18 families in which housekeeper service has been used home and family ties have been preserved for 65 children. Thus housekeeper service is a device that has proved very useful in helping to maintain "for every child a home and that love and security which a home provides."

Award for Service to Children Goes to Miss Lenroot

In connection with the observance of Better Parenthood Week, September 23–29, the 1940 award offered by *Parents' Magazine* for outstanding service to children was given to Katharine F. Lenroot, Chief of the Children's Bureau. George J. Hecht, chairman of the Better Parenthood Week Committee and publisher of *Parents' Magazine* declared that Miss Lenroot was awarded the medal for 26 years of outstanding service and "because she is known in this country and abroad as the best friend of America's children."

Miss Lenroot, in accepting the medal, said:

> The present emergency makes it important that we press forward to provide our children with decent homes, nourishing food, health service and medical care, schooling that prepares for citizenship, and protection against child labor. The American people have resolved that the lives of mothers and babies are not to be needlessly sacrificed and that the health, education, and welfare of the younger generation are matters of national as well as local and parental concern.

BOOK NOTES

BORROWED CHILDREN, by Mrs. St. Loe Strachey. Commonwealth Fund, New York, 1940. 149 pp. 75 cents.

The evacuation of children from English cities to rural parts of England in September 1939, some of the problems encountered, and their remedies are described in this small book, which was first published by John Murray, London, in July 1940.

How They Came and What Has Happened Since are the self-explanatory titles of the two main parts. The case material presented is the result of the planned work of the Mental Health Emergency Committee, representing five societies interested in psychological problems. This committee set up a register of social workers with training in mental health and organized emergency child-guidance clinics to which foster parents and "hostesses" of "billeted" children could come for help with children who were not adjusting themselves satisfactorily to their new situation. Some of the problems dealt with grew out of unfavorable situations in the homes from which the children came; others were the direct result of the uprooting and separation inherent in the fact of evacuation. Many instances are given of anxiety resulting in enuresis or stealing.

The clinic workers were able to clear up many of the situations by bringing about better understanding between child and foster mother and thus increasing the child's feeling of security. In some cases the child was rebilleted with a less exacting family. A home was opened for children who were unable to fit into ordinary homes; 20 children at a time lived in this home, which supplied a favorable environment and direct treatment.

One chapter, "Running Wild," describes the plight of some 800,000 children in cities where schools were closed who were not evacuated or who returned to their homes after evacuation and who were listed by the school authorities in March 1940 as "unaccounted for."

This brief report points up vividly the problem of adjusting children and billet-parents which had to be met and which has many implications for those in the United States who are caring for child refugees.

THEORY AND PRACTICE OF SOCIAL CASE WORK, by Gordon Hamilton. Columbia University Press, New York, 1940. 388 pp. $3.

The author states in the preface that she has not attempted to offer a wholly new interpretation of case work but that she does attempt to analyze and reconcile some of the more significant elements of theory and practice today. In chapters 1–10 consideration is given chiefly to the general aspects and in chapters 11–14, to the functional adaptations of social case work.

The theory of case work is discussed and illustrated by case material presented in great detail. Case illustrations have been drawn from records of clinics, courts, hospitals, public and private social agencies—particularly family and children's agencies.

1940 YEARBOOK, PARK AND RECREATION PROGRESS. National Park Service, U. S. Department of the Interior, Washington, 1940. 92 pp.

Illustrated with photographs, maps, and drawings, this yearbook contains articles by authorities in the park-service and related fields. Camping, bicycling, recreational-area planning, recreation as a by-product of reclamation, and the role of the museum in public recreation are among the subjects covered.

THE JUVENILE LAWS OF CALIFORNIA; including Federal statutes, by Joseph F. Triska, LL. B. Research Publishing Co., Los Angeles, 1940. 349 pp. $5.

All the laws of California that relate to minors are presented in readable form, classified by subject: Parent and Child; Legitimacy; Adoption; Education; Marriage; Employment; Guardianship; Legal Status; State Welfare; Delinquency; Juvenile Court Law; Succession; and Offenses Against Minors.

Under the title, Employment, are classified laws on wages, hours, and working conditions; prohibited occupations; maximum hours and night employment; and apprenticeship.

The chapter on State Welfare includes laws relating to the protection of physically handicapped children; to the commitment of incompetents; to orphanages, institutions for child care, home-finding agencies, institutions for the feeble-minded and for the blind; and to the Children's Court of Conciliation, which has jurisdiction in controversies between spouses having any minor child whose welfare might be affected by disruption of the household.

Appendixes summarize orders issued by the State department of industrial relations which have the force of law and Federal statutes applicable to minors.

The phraseology is simplified for the most part, and code provisions and court decisions dealing with administrative functions and court practice and procedure are omitted.

PARENTS AND CHILDREN GO TO SCHOOL; adventuring in nursery school and kindergarten, by Dorothy Walter Baruch, Ph. D. Scott, Foresman & Co., Chicago, 1939. 504 pp. $3.

The author, who is director of the preschool and parent-education department and professor of education, Broadoaks School of Education, Whittier College, has described in detail what goes on in one preschool composed of nursery and kindergarten groups. Emphasis is placed on the consideration of the whole child, the place of mental hygiene, the necessity for cooperation of the home and school, and the importance of the early years of a child's life.

• CHILD LABOR •

• YOUTH EMPLOYMENT •

• VOCATIONAL OPPORTUNITIES •

Child-Labor Standards and Defense Contracts

By Savilla Millis Simons

Industrial Division, U. S. Children's Bureau

It is a source of great satisfaction to those interested in the protection of children that, in the increased production for defense purposes, a determined effort is being made to maintain present labor standards. The National Defense Advisory Commission unanimously adopted on August 31 a statement of labor policy for the guidance of contractors who receive national-defense orders from the United States Government. Among other provisions this statement calls for compliance both with Federal laws affecting labor, including the Fair Labor Standards Act, the Walsh-Healey Act, and the National Labor Relations Act, and with State and local statutes affecting labor. Through this provision the defense labor policy calls for observance of the child-labor provisions of the Fair Labor Standards Act, which contains a basic 16-year minimum-age standard for establishments shipping goods in interstate commerce, and of the State child-labor laws.

When the defense program first swung into action some public opinion favored lengthening hours in order to increase production. The Defense Commission's labor policy states that "all reasonable efforts should be made to avoid hours in excess of 40 per week" and that overtime rates should be paid "when the requirements of the defense program make it necessary to work" more than 40 hours per week. This espousal of the 40-hour week is highly important not only as a safeguard to the welfare of young workers but as a measure to facilitate absorption of unemployed youth and adults.

Connected with the Defense Commission's labor policy is the new use of negotiated contracts for Government purchases for the War and Navy Departments. On September 6 the Defense Commission adopted a statement of general principles governing the letting of defense contracts which authorized the use of negotiated contracts. This was made possible by a recent enactment of legislation by the Congress, providing for the awarding of contracts "with or without competitive bidding." Formerly the Government was required to buy through competitive bidding; under this system, the award of the Government contract went automatically to the lowest bidder.

Under the negotiated contract a number of factors in addition to that of price may be taken into consideration, including the firm's labor record. Among other factors to be considered in the negotiated contract are speed of delivery, proper quality, health and housing facilities for employees, the avoidance of undue geographic concentration, possible off-season production in order to dovetail the military program with production to meet civilian needs, and the financial and moral responsibility of the firm.

On September 13 President Roosevelt sent both the statement of general principles governing the letting of contracts and the statement of labor policy to Congress for the information of the members. On October 1 Sidney Hillman, Commissioner in Charge of the Labor Division of the National Defense Advisory Commission, made public letters from Secretary of Navy

Knox and Assistant Secretary of War Patterson, stating that contractors would be informed that full compliance with these principles would be expected and that procedures were being formulated whereby the principles and labor standards set up in these statements could be incorporated in all contracts awarded.

The leadership which the National Defense Advisory Commission has taken to insure the maintenance of the labor standards, which have been found over a long period of years to be in the best interests of the Nation, is a sign that in carrying forward this tremendous defense effort, due regard will be given to the well-being of the workers as a means of promoting efficiency in production as well as the general welfare.

I. A. G. L. O. Convention

At the Twenty-sixth Convention of the International Association of Governmental Labor Officials, which met in New York September 9–12, 1940, the report on child labor was given by Beatrice McConnell, chairman of the Child Labor Committee. Miss McConnell is Director of the Industrial Division of the United States Children's Bureau. The report covers progress during the year in child-labor legislation in the United States and Canada, protection of migrant children, regulation of the employment of minors in hazardous occupations under the Fair Labor Standards Act, and issuance of age certificates under the Fair Labor Standards Act of 1938 and the Sugar Act of 1937. It stresses the need for establishing standards and administrative techniques for handling the employment of children in street trades and industrialized agriculture.

It also points out the importance of safeguarding existing child-labor standards in times of urgency such as the present and of giving "the children and youth of this country every possible opportunity for their education and training and for their intellectual, moral, and physical development so that they may be equipped with the necessary ability and zeal to meet the great responsibilities of the coming year."

In line with the child-labor report is the following resolution which the convention adopted on youth labor standards:

> In a program of national defense it is of paramount importance [to the Nation] to safeguard and promote the health, safety and morale of its workers, in particular of its youthful workers, while they are being introduced to industry and seasoned in its processes.
>
> This conference, therefore, emphatically urges that at no point shall there be relaxation of the legal standards that have been built up for the protection of young workers from too early or too hazardous employment, or that otherwise safeguard them on the job or in training.
>
> Attention is called to the fact that experience has shown that such safeguards are not only for the good of the individual but tend to increase production. . . .

Other resolutions reflect the preoccupation of the conference members with problems associated with the international situation and national-defense plans. One resolution welcomes to North America the International Labor Organization, which is transferring a large part of its personnel from Geneva to Montreal. Other resolutions deal with the training of factory inspectors and the extension of minimum-wage systems. A resolution on Central and South American representation extends a cordial invitation to all governmental labor agencies of the Republics and political Divisions and subdivisions of the Americas, islands and possessions included, to become affiliated with the I. A. G. L. O. in order to protect their mutual interests.

Brazil

Regulation of child labor in street trades

Under the Presidential Decree regulating street trades in Brazil, issued February 27, 1940, minors under 18 years of age may not be licensed as street traders on their own account. Minors under 18 may be licensed to be employed in street trades only if they present proof of age, authorization from parent or legal guardian, a physician's certificate of physical and mental fitness, and a certificate of vaccination. (Under the Children's Code of 1927 (sec. 112) no boy under 14 or unmarried woman under 18 may engage in street trades.)

A maximum working day of 8 hours is prescribed for minors under 18 in street trades, and work between 10 p. m. and 5 a. m. is prohibited for children under 16.

Street dealers in foods and drinks must be examined at least once a year by a physician in public service; the license is to be revoked in case of communicable disease.

The decree will be administered by inspectors of the Department of Labor and by the local public-health and police authorities.

Boletim do Ministerio do Trabalho, Industria, e Comercio, Rio de Janeiro, No. 67, 1940, p. 40.

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Commission for revision of laws appointed

For the purpose of putting into practice the clauses of the Federal Constitution of 1937, relating to the employment of women and children, the Minister of Labor of Brazil has recently appointed a commission which is charged with the task of examining the existing legislation for the protection of working women and children and making recommendations.

Ibid, No. 68, p. 71.

NEWS NOTES

Puerto Rico designated

Puerto Rico has been designated as a State in which State work permits and age certificates are acceptable as proof of age under the child-labor provisions of the Fair Labor Standards Act. The Insular Department of Labor has been designated as the supervising agency, and the Department of Education and the Health Department on the Island will cooperate also in the general program. The designation became effective September 20, 1940, for the period ending June 30, 1941.

The designation of Puerto Rico brings to 45 the number of States and United States jurisdictions so designated.

Aid to migrants

A report dealing with the social problems of migratory workers and their families and making recommendations for State and Federal action was presented to President Roosevelt in July 1940 by the Interdepartmental Committee To Coordinate Health and Welfare Activities (Migratory Labor—A Report to the President, July 1940; 21 pp. Mimeographed). Its recommendations include proposals for:

A series of State-Federal regional conferences to promote public understanding of the migratory-labor problem.

Federal aid for educational, recreational, and welfare services to communities with large migrant groups.

Expansion of the Farm Security Administration's camps for migratory agricultural workers, and Federal provision for permanent garden homesteads for migrants who obtain year-round jobs on nearby farms.

A Federal-State program, backed by an initial $5,000,000 appropriation under the Social Security Act for the current fiscal year, to provide health and medical services for migrants.

Closer Federal supervision of working conditions for migrant laborers through Federal regulation of interstate-labor contractors.

Interstate Commerce Commission regulation of the transportation of workers across State lines by truck.

Expansion of the farm-placement service.

Extension of wage-hour coverage to agricultural migrants.

Protection for children of migratory workers against employment at too early an age or under unfavorable conditions.

Extension of the social-security programs, including public assistance, old-age insurance, and unemployment compensation to migrants.

To meet the emergency situations that have developed, provision of more effective immediate aid for migrants and their families and of a continuing program of aid through a general relief program established on a Federal-State basis.

The assurance to migratory workers of "the civil rights to which all citizens are entitled."

The recommendations are premised upon closer working relationships and better coordination among Federal and State agencies with responsibilities in the several fields involved.

The Committee recognizes that no public service or protection is a substitute for adequate job opportunities. While it believes the steps indicated are urgently needed, it urges also that continued study and effort be devoted to meeting the basic economic problems in which these and other immediate needs are rooted.

BOOK NOTES

Publications of NYA State offices Occupational Information Research Reports recently received from State Youth Administrators are as follows:

Aircraft Industry. Revised edition. National Youth Administration for Illinois, Chicago, June 18, 1940. 53 pp. Mimeographed. Job descriptions and qualifications particularly have been treated more comprehensively than in the 1936 edition.

Hosierymaking—Nylon and Silk, by Robert S. Richey. National Youth Administration for Indiana, Indianapolis, May 15, 1940. 25 pp. Mimeographed.

The Railroad Industry, by Lotys Benning Stewart. National Youth Administration for Indiana, Indianapolis, August 1940. 119 pp. Mimeographed.

Tung Oil Production in Mississippi. National Youth Administration for Mississippi, Jackson, May 1940. 59 pp. Mimeographed. This report, which traces the use of tung oil in China back to the days of Marco Polo, was written by John Godbold and illustrated in pen and ink by Florian Nesossis.

The Machine Tool Industry in Ohio. National Youth Administration in Ohio, May 1940. 119 pp. Mimeographed. This report, by Wilbur R. Hanawalt, is illustrated by photographs and drawings, and tells the story of machine tools from the caveman's first hand-drill. A chapter on training for machine-tool work contains a description of the apprenticeship system.

GUIDANCE PROGRAMS FOR RURAL HIGH SCHOOLS, by Paul W. Chapman. Vocational Division Bulletin No. 203, U. S. Office of Education, Washington, 1940. 58 pp.

To assist the 17,000 smaller high schools, which for the most part serve rural youth, in organizing vocational-guidance programs is the purpose of this bulletin.

It is divided into four parts. In part 1 is presented the desirability of making vocational-guidance services an organic part of the program of every school; attention is called to the peculiar problems of high schools in rural areas. Parts 2 and 3 are reports of the guidance programs in two school systems in New York State —Newark Valley Central School and the Rockland County schools. Part 4 presents an outline of the functions of the complete guidance service for a local school system. The appendix contains 18 forms used in connection with the guidance services of the Nyack schools (in Rockland County).

YOUTH IN AGRICULTURAL VILLAGES, by Bruce L. Melvin and Edna N. Smith. Research Monograph 21, Division of Research, Works Progress Administration, Washington, 1940. 143 pp.

The school attendance and educational attainment, employment, and occupations of village youth are given a chapter each in this monograph. Other aspects of the life of village youth which are discussed include their mobility, personal characteristics, financial status, and social and recreational activities. One chapter is devoted to economically independent youth away from the villages. The age covered is 16 to 29 years of age, the 25- to 29-year-old group being included in order to show how those who were "near the mid-point of the youth age at the beginning of the depression of the early thirties have made their adjustments." In some of the tables two totals are given—for youth 16 to 24 years of age and for youth 16 to 29 years of age.

Underemployment is emphasized in the summary, rather than unemployment, as the outstanding occupational difficulty among village youth. Nevertheless, when out-of-school youth 16 to 24 years of age are considered, it appears that 13 percent of the boys and 36 percent of the unmarried girls were unemployed at that time. The proportion of young persons of both sexes who were neither in school nor gainfully employed was greatest for the 16-17 year age group (31 percent for the boys and 52 percent for the girls). The survey was made as of June 1, 1936, a period when agricultural employment was at a high level, and youth were classified as employed if they had worked for pay at least 1 day each week during the 2 weeks preceding that date. Youth engaged in emergency employment were also classified as employed.

FACTORIES IN THE FIELD LURE THE BAREFOOT BOY. New York Child Labor Committee, 105 East Twenty-second Street, New York. 12 pp.

A "sampling" of child-labor conditions on large truck farms in central New York in the summer of 1939, summarized in this illustrated pamphlet, indicated that as many as 10,000 to 15,000 child workers are so employed in the State of New York. Investigators found children 8 years of age and up carrying baskets too heavy for their strength; overcrowded trucks taking children to the field (8 instances of truck accidents in which 19 boys and girls were injured); illness among child workers due to impure water, heat exhaustion, and acute plant poisoning; and cases of children who had been struck by overseers because they were not working hard enough.

• EVENTS OF CURRENT INTEREST •

"Raising a President"

A weekly series of radio programs is being given by the Children's Bureau on the general theme of "Raising a President." These programs can be heard over the blue network, National Broadcasting Company, at 2 p. m., Eastern standard time. The first 13 programs, beginning October 2, 1940, are concerned with various aspects of food and nutrition and consist of a brief dramatization followed by discussion. The subjects for November and December are as follows:

November 6—The Recess Bell! A discussion of school lunches.

November 13—Time Out To Eat; a discussion of food for the whole family.

November 20—Food Dollars and Sense; budgeting for food according to the size of the pay envelope.

November 27—Substitutes for the Sun; selecting foods to take the place of sunlight.

December 4—Grow While You Sleep; the connection between nutrition and sufficient sleep.

December 11—Children and the Defense Program.

December 18—Helping Santa Claus.

December 25—How To Live With Children and Love It!

New Constitution of Paraguay

The new Constitution adopted in Paraguay in July of this year and replacing the Constitution of 1870 requires the establishment of free primary schools with compulsory attendance and directs the Government to promote secondary and vocational education. Among the fundamental duties of the State the Constitution names social aid, the care of the population's health, and physical education of young people.

Laws will be necessary to put these principles into practice.

Official copy of the Constitution.

CONFERENCE CALENDAR

Nov. 10–16 American Education Week. Twentieth anniversary. Information and program material from National Education Association, 1201 Sixteenth Street NW., Washington, D. C.

Nov. 10–16 Children's Book Week. Information and manual of suggestions from Book Week Headquarters, 62 West Forty-fifth Street, New York.

~~Nov. 12–14 Seventh National Conference on Labor Legislation. Called by the Secretary of Labor, Washington, D. C.~~

Nov. 12–15 Southern Medical Association. Thirty-fourth annual meeting. Louisville, Ky. Permanent headquarters: Empire Building, Birmingham, Ala.

Nov. 12–15 American Society of Tropical Medicine, Louisville, Ky. Secretary: Dr. E. Harold Hinman, Wilson Dam, Ala.

Nov. 13–15 National Association of Day Nurseries. Second annual conference, New York. Permanent headquarters: 122 East Twenty-second Street, New York.

Nov. 15 National Council for Mothers and Babies. Annual meeting, Hotel Washington, Washington, D. C.

Nov. 15–16 Child Study Association of America. Two-day institute, Hotel Roosevelt, New York. Permanent headquarters: 221 West Fifty-seventh Street, New York.

Nov. 18–20 American Academy of Pediatrics. Annual meeting, Memphis, Tenn. Secretary-Treasurer: 636 Church Street, Evanston, Ill.

Dec. 4–8 American Public Welfare Association. Annual round-table conference, Washington, D. C. Permanent headquarters: 1313 East Sixtieth Street, Chicago.

Dec. 8–9 Associated Women of the American Farm Bureau Federation. Annual convention, Emerson Hotel, Baltimore, Md.

Dec. 9–12 American Farm Bureau Federation. Annual convention, Baltimore, Md.

Dec. 26–28 American Statistical Association. One-hundred and second annual meeting, Chicago. Secretary: Frederick F. Stephan, 1626 K Street NW., Washington, D. C.

Dec. 27–29 American Sociological Society and affiliated organizations. Annual meeting, Chicago.

Dec. 27–30 American Economic Association and Southern Economic Association. Annual meeting, New Orleans, La.

Dec. 27–30 American Library Association. Midwinter conference, Chicago. Permanent headquarters: 520 North Michigan Avenue, Chicago.

Dec. 27–30 American Association for Labor Legislation. Thirty-fourth annual meeting, Chicago. Permanent headquarters: 131 East Twenty-third Street, New York.

NOTICE!

The Seventh National Conference on Labor Legislation, previously scheduled for November 12, 13, 14, has been postponed to December 9, 10, 11. The Conference, which meets in Washington, D. C., at the call of the Secretary of Labor, serves as a medium for clearance and cooperation among State labor commissioners and administrators and representatives of organized labor appointed by the State Governors.

U. S. GOVERNMENT PRINTING OFFICE: 1940

UNITED STATES DEPARTMENT OF LABOR

Frances Perkins, Secretary

CHILDREN'S BUREAU

Katharine F. Lenroot, Chief

The Child is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives The Child.

The Child is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to the editor, The Child, Children's Bureau, United States Department of Labor, Washington, D. C.

The Child is for sale by the Superintendent of Documents, Washington, D. C., at $1 a year; foreign postage, $0.50 additional. Single copies are 10 cents each. Subscription orders should be addressed to the Superintendent of Documents, Government Printing Office, Washington, D. C.

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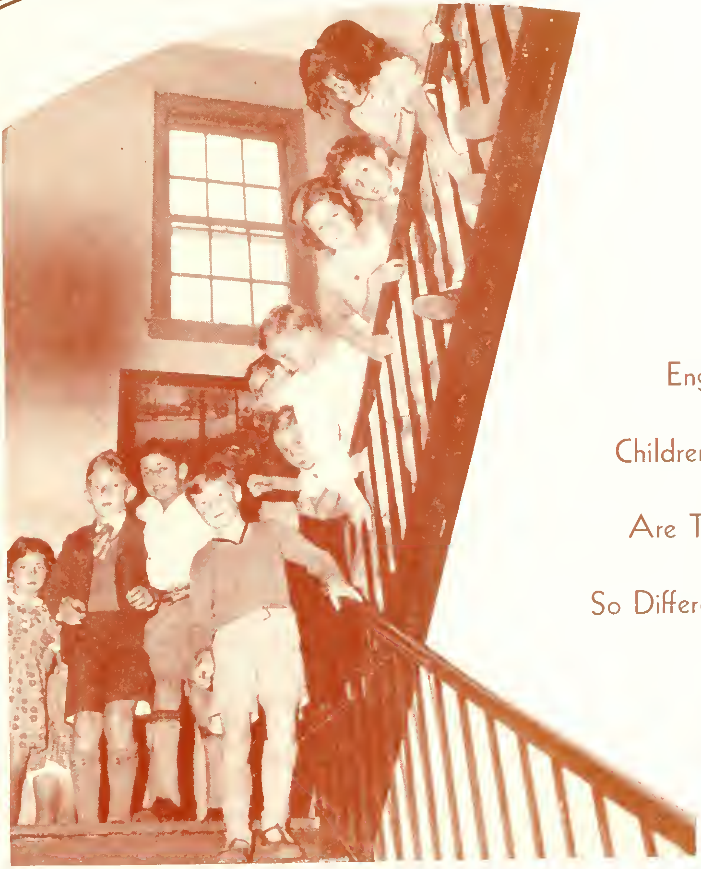

English Children— Are They So Different?

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

NOV.–DEC. 1940

THE CHILD MONTHLY BULLETIN

Volume 5, Numbers 5 and 6 November–December 1940

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JAN 14 1941

• THE • WORLD'S • CHILDREN •

English Children—Are They So Different?

By Eric H. Biddle, *Vice President and Executive Director,*

United States Committee for the Care of European Children, Inc.[1]

EVERY time a group of English children come down the gangplank to be America's guests for the duration of the war you hear some one say, "What lovely children! What a pity they had to leave home! Look how well behaved they are!"

The bystanders are right. It would be difficult to find anywhere an equal number of children who are more satisfactory guests.

The temporary suspension of overseas evacuation by the British Government has afforded us an opportunity for reviewing our experiences with our first 1,000 child guests. We can now say with assurance that the needs of the English child are similar to those of the American child. Our acceptance of European children carries with it the acceptance of responsibility like that which we assume for our own children.

Children, regardless of nationality, have the same emotional desires. They are eager for group acceptance.

Our young guests, Derek and Gillian, are eager to fit into our home and our town and our customs. They want to wear the same type of clothes as the American children with whom they associate. If corduroy knickers are the vogue in the grade school around the corner, it's corduroys that Derek wants. If a scarf is being worn by the junior-high-school girls instead of a hat, it's a scarf for Gillian.

They yearn to be proficient at American games—football, basketball, roller and ice skating. One young evacué who is eager to be a part of his environment of the Southwest has started to walk bowlegged in preparation for becoming a proficient cowboy. Like our American children, many of the English seem to prefer the radio's hair-raising adventure serials to educational broadcasts or programs usually called good for children.

The sooner the young guests come to feel a part of the community the better. One foster parent who lives in the desert country invited several Indian, Mexican, and American children to a picnic so that his English guest might more readily become part of the gang. The host arranged for a typical American repast, one that had been served by President Roosevelt to the King and Queen of England at Hyde Park: hot dogs. This kind of entertainment is better for the child and more satisfying to him than the American idea of an English party planned exclusively for English children that has occasionally been arranged by those who sincerely wanted to extend hospitality to young guests in a community.

The English children for the most part have come to this country in a spirit of high adventure. They have been looking forward to new experiences and are ready to enter into them with interest and enthusiasm.

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[1] 215 Fourth Avenue, New York, N. Y.

The adjustment of the visitors to many new situations is excellent. One of our staff members had this experience. She was escorting several children on an overnight trip in the sleeping car. About 2 o'clock in the morning, when all were asleep, the car developed a hotbox and the porter came through to tell the passengers that they would have to transfer to another car. One of the older boys awoke and called down from his upper berth, "I say, what's the fuss? Is it an air raid?" When the situation was explained he said, "How jolly!" The next morning he was not only unmindful of his broken sleep but thoroughly enchanted to learn that the railroad served free breakfast to passengers on the sleeping car who had been inconvenienced by equipment trouble.

Security is a fundamental need of every youngster, regardless of his nationality. Any child wants to belong to an affectionate family group and to take part in the homely day-to-day activities of that group.

These English children have all gone through a difficult series of experiences. For more than a year they lived in the physical insecurity of war-time conditions. They have been separated from family and friends. Now, after a hazardous train trip from London to the port of embarkation, followed by a disconcerting and dangerous ocean voyage, they have come to a strange country and have been received in a strange community and home by adults they have never seen.

To add to their confusion their expectations were colored by the exaggerations of American motion pictures, by newspaper emphasis on the bizarre, by caricatures in magazine articles and books, and by anecdotes about the American tourist. Now that they are here they find many things are different from the English way. American houses, public buildings, and trains seem hot. Schools follow an entirely different pattern from the schools they knew in England. Food is unfamiliar. Milk is the usual drink for children instead of tea. Kidney pie and suet pudding are virtually unknown. After the novelty has worn off, American food seems bland.

Inevitable homesickness and nostalgia for familiar experiences and familiar surroundings are difficult for child and foster parent alike. These children must work through the problems that confront any growing child, and they must work them through in a new environment and among people who, however friendly, have been strangers to them.

Fleeting unhappiness is often a source of deep concern to substitute parents. Lavish gifts or elaborate parties that emphasize the difference between these children and others in the community do not relieve the unhappiness nor is it possible to recreate in this country the child's own family life for him, but the feeling that the foster parent is trying to understand the child's point of view may do much to alleviate these intermittent pangs. One foster parent, for example, tries to have dinner one day a week as nearly as possible like those the children's mother had for them in England, following their suggestions as to menu. This foster parent admits that she doesn't like English kidney pie any more than her guests like creamed chicken on toast, which they find tasteless. After eating 1 meal of English food out of 21, the foster parent has a keener understanding of the children's occasional lack of enthusiasm for American food. Foster parents and children find that the efforts to share experiences make their problems more easily recognizable and simpler.

A problem frequently arises concerning discipline. One foster mother and father told us that they had received a letter from the parents of their guests. The parents wrote: "This is the way Alan may act and this is what you can expect from Mavis. They are typical children, and this is the way we discipline them." The foster parents were disinclined to use the rigorous disciplinary methods suggested. They believe, however, that the children have responded well to the approach they have worked out as more appropriate to the nature of their relationship to the children.

Another American foster parent who has three English children laid before the young guests the idea of convening "Parliament" when difficulty arises. Any member of the family who has some request to make or grievance to talk over can call the group together by sounding a small dinner bell.

A few days ago, the call to "Parliament" was heard through the house. The youngest member of the family protested that "Momsey" was unfair! She wouldn't let him have a banana. This was admitted, but Momsey won support of the majority when cross-examination revealed that the youngster had just finished seven bananas.

A little weightier question was the purchase of bicycles for the children. When the situation was thoroughly explored in "Parliament" it was agreed that the real obstacle was the danger arising from heavy traffic in the neighborhood, and the petitions for "bikes" were withdrawn. This same forum settles problems such as weekly allowances for the children and even the question of long trousers for one of the boys.

A problem of particular significance in the care of guest children lies in the fact that the period in America is looked upon as a temporary experience and in most instances is but an interlude, after which the children will return to their own families.

One English family wrote, "Please keep Colin's living simple because we'll be poor after the war." We have tried to arrange placements in American homes of economic circumstances similar to those from which the child has come. It is obvious that the English child's home cannot be duplicated for him, but it is possible to minimize the necessity for drastic adjustment to an American home, to be followed by an equally drastic readjustment when the child returns to his own family.

As every worker with children knows, children normally trust adults. Most of the guest children go halfway to meet their foster parents. It is to be expected, however, that these guest children should have some difficulty establishing with their foster parents a relationship that does not disturb their feelings of loyalty to their own parents.

In one home where there were two English children aged 7 and 9 years, the 7-year-old started to call his American hosts "Mom" and "Pop." The 9-year-old corrected the boy with "Don't call them Mom and Pop. They are not your mother and father." The use of parental terms of address may give much-needed feeling of security, but the terms used in a particular situation need to be selected to suit the needs of the child and to help him to sustain the tie which he naturally feels to the parents he has left behind.

The sojourn of the English child in this country should afford him opportunities for new experiences and fulfill his need for security in ways that will give a feeling of continuity of the present with the past and the future.

Care for the English children, it seems to me, does not generally require an entirely different method of child-placing and care. Foster-home programs in operation under the direction of child-caring agencies cannot provide foster care for English children on arbitrary standards any more than they can for American children. There are going to be as many kinds of placements as there are children and foster homes.

English children are not essentially different from our own children. They have similar emotional reactions. They are eager for group acceptance and recognition. They likewise seek security, love, and protection. They must be given help in fulfilling these needs. If these facts can be accepted, we may approach our task with confidence in the ability of the American people and the American home to provide for our English visitors.

Child-Welfare Legislation in Brazil

By Anna Kalet Smith

Associate in Foreign Research, U. S. Children's Bureau

EARLY HISTORY OF CHILD-WELFARE WORK

In the light of the present movement in Brazil for a nation-wide system of more effective child-welfare work, it is of interest to recall that country's early experience in the service of its children. After the appearance of white settlers in Brazil early in the sixteenth century institutions were established for orphans and deserted children. These institutions remained practically the only form of child-welfare work during Brazil's 300 years of colonial history and its subsequent period of monarchy. The institutions, open to orphans and to destitute and abandoned children, were usually under the charge of religious orders.

With the increase in demand the number of private institutions for orphans and dependent children grew rapidly, and some Government institutions were established. In all this work the main efforts continued to be centered on the relief of distress. The need for prevention of dependency and illness was practically unrecognized in Brazil until recent years.

The first attempt to modernize child-health services and to bring out the value of preventing illness among children and of teaching mothers proper child care was made early in the present century. It was then also that new types of agencies, such as child-health centers, children's milk-distributing stations, children's clinics, and kindergartens began to appear and "gave to the child-welfare movement a breadth and force never before known in that country."[1]

WORK OF PRIVATE AGENCIES IN RECENT YEARS

All this work was done at first mainly by private agencies. The most important of these, the Institute for the Protection of and Assistance to Children of Rio de Janeiro (Instituto de Protecção e Assistencia á Infancia do Rio de Janeiro), was founded in 1899 by Dr. Arthur Moncorvo Filho, famous in the field of pediatrics and child health. This institute, which has at present more than 20 branches throughout the country, is maintained jointly by private donations and by grants from the Federal Government and the city of Rio de Janeiro. Aiming to serve the poor people, it has established prenatal and child-health centers, clinics for the medical treatment of children and mothers, and day nurseries; it has provided instruction in hygiene to mothers, attendance at home during childbirth, and has distributed clothing and food.[2]

Dr. Moncorvo, however, had felt the need of supplementing the work of the institute by that of another agency which would study the problems of child welfare and advise the Government and the public as to needed steps. Having followed the work of the United States Children's Bureau since its organization, Dr. Moncorvo conceived the idea of organizing a similar agency in his own country and in 1919 founded the Departamento da Criança no Brasil.[3]

While the institute is engaged in practical health work for mothers and children, the Departamento is engaged mainly in research work. The Departamento announced among its purposes the study of child welfare in Brazil and work for the improvement of child-welfare legislation and for the establishment of various maternal and child-welfare institutions. In 1922 the Departamento organized the first Brazilian Congress of Child Welfare on the occasion of the centenary of Brazilian independence. It has established the "Museum of Childhood," which is a permanent exhibit in the field of child welfare; it has published a history of child welfare in Brazil, a compilation of child-welfare laws of Brazil, and numerous pamphlets on hygiene and child care; it answers requests for information from the Government of Brazil and from other sources; it has prepared a register of child-welfare agencies in Brazil; and it maintains a library on child welfare and related subjects. The Departamento has been maintained by private gifts, but in recent years it has been receiving subsidies from the Federal Government.

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[1] Freire de Vasconcelos, Dr. J., and Dr. Silveira Sampaio: Problemas Medico-Sociais da Infancia. p. 181. Rio de Janeiro 1938.

[2] Departamento da Criança no Brasil: Rapida Noticia sobre o Instituto de Protecção e Assistencia á Infancia do Rio de Janeiro. Boletim do Anno de 1935. Rio de Janeiro, 1936.

[3] Moncorvo Filho, Dr. Arthur: Departamento da Criança no Brasil. Rio de Janeiro, 1940.

BEGINNING OF FEDERAL CHILD-HEALTH WORK

The first step in the direction of child-health work was taken by the Federal Government in 1920 with the establishment of a section on child hygiene (Secção de Higiene Infantil) in the newly organized National Bureau of Public Health. The section, with its work confined to the Federal District, established three child-health centers.[4] In the following year the section was replaced by the Inspetoria de Higiene Infantil with the assignment of child-health and child-welfare work in the Federal District. In addition, the Federal Government was allowed to direct, through the Inspetoria, the child-health work in the States but only upon arrangement between each State and the Federal Government.[5] Soon, however, the experience of other Latin American countries was repeated in Brazil, and both the public and the Government began to see the inadequacy of the scattered and unorganized efforts by private agencies and by the States with their varying degrees of development. The need for governmental action on a nation-wide scale was becoming more and more apparent.

Federal action was greatly encouraged by Getulio Vargas, who, soon after becoming President in 1930, called attention to the inadequacy of child-welfare services in Brazil, and on Christmas Day in 1932 issued his often-quoted message to the governors of the States, which is considered as the opening of a new era in social reconstruction in Brazil.[6] In this message the President appealed to the governors and the public to combine their efforts for preserving the lives and health of children and giving them better opportunities for physical and mental development. In the following year a National Conference for the Protection of Childhood, called by the President and attended by delegates from all the 20 States of Brazil, the Federal District, many municipalities, and private agencies, prepared a program of nation-wide action, which included plans for a national agency of maternal and child welfare.

One of the first results of the conference was the creation in 1934 of the Division of Maternal and Child Welfare (Diretoria de Protecção á Maternidade e á Infancia), which replaced the Inspetoria de Higiene Infantil. This Division was given more authority than its predecessor; it was entrusted with the promotion of health and welfare work for mothers and children in the entire country[7] through helping to establish institutions and agencies and to organize co-operation among the Federal, State, municipal, and private agencies.

FEDERAL CONSTITUTIONS OF 1934 AND 1937

The Federal Constitution enacted in 1934 contained a principle unknown in the previous constitutions of Brazil and said to have been inspired by President Vargas;[8] namely, it placed upon the Federal Government, the States, and municipalities the duty of assuring, through special laws, the protection of mothers and children and other dependent groups. Still more significant in its social spirit is the Constitution of 1937, which places on the Government for the first time the duty of giving "special care" to children and young people and "taking all measures necessary to assure for them" the conditions of a healthy and normal life. Destitute parents are given the right to ask aid from the Government for the maintenance and education of their children.

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[4] Fontenelle, J. P.: A Saúde Publica no Rio de Janeiro, Distrito Federal, 1935 e 1936. [No imprint.]

[5] Collecção das Leis da Republica dos Estados Unidos do Brasil, Vol. 3, Pt. 1, p. 665. Rio de Janeiro, 1923.

[6] *Boletín del Instituto Internacional Americano de Protección a la Infancia* (Montevideo), Vol. 14, No. 1 (July 1940).

[7] *Boletim Trimensal do Departamento Nacional da Criança* (Rio de Janeiro), Vol. 1, No. 1 (June 1940).

[8] Boletín del Instituto Internacional Americano de Protección a la Infancia (Montevideo), Vol. 14, No. 1 (July 1940).

REORGANIZATION OF FEDERAL CHILD-HEALTH AND WELFARE WORK

As newer concepts of child-health work were evolved, Federal services were again reorganized, and the Division for the Protection of Mothers and Children (Divisão de Amparo á Maternidade e á Infancia) in 1937 replaced, with greater resources and authority, the Diretoria de Protecção á Maternidade e á Infancia. The Division studied problems of child health, distributed Federal aid to the States for maternal and child-health work,[9] and collaborated in the establishment of maternal and child-health centers in various localities. At these centers popular literature on child care, published by the Division, was distributed. A study of child feeding in Rio de Janeiro was made by the Division, which also maintained in Rio de Janeiro the Instituto de Puericultura, a prenatal and child-health center attended in 1939 by 41,000 children and 5,200 expectant mothers.[10] It was also the function of the Division to furnish advice and information on the organization of child-health centers.

The National Council of Social Welfare (Conselho Nacional de Serviço Social) was organized under a presidential decree of July 1, 1938,[11] for study of problems of social welfare, investigation of living conditions among destitute or socially maladjusted children, preparation of plans for social-welfare work in the entire country, and distribution of Federal subsidies to private agencies.

The Council, consisting of seven members, is appointed by the President of the Republic from among persons experienced in social-welfare work. The members are paid a specified amount for each day of their services.

In compliance with the new Constitution, President Vargas appointed in November 1939 the National Commission on Protection of the Family. The Commission was given the task of drafting child-welfare bills.

On December 24, 1939,[12] the President called on the States, the municipalities, private agencies, and the entire population to join efforts in child-welfare work.

FEDERAL SUBSIDIES TO PRIVATE CHILD-WELFARE ORGANIZATIONS

Another step toward the practical application of the Constitution of 1937 was the provision of Federal grants, under a law of 1938, to private agencies engaged in welfare or educational work for children or adults. The applying agency must state the use for which the subsidy is intended and must prove, among other things, that the agency was legally organized, that it has been functioning continuously for more than a year, that it has a regular but insufficient income, and that it receives no other aid from the Federal Government. The documents submitted for this purpose must be certified by specified public authorities.[13] The organizations applying for aid must submit an accounting of any subsidy previously received.

The application is sent to the Ministry of Education and Health, which submits it for consideration to the Council of Social Welfare and acts on the Council's decision. The subsidies are made available from a special appropriation of the Ministry of Education and Health.

NATIONAL CHILDREN'S BUREAU, 1940

In the face of new experiences and new needs the Division for the Protection of Mothers and Children, confined to health work, was soon found to be too limited in its activities and was replaced by the National Children's Bureau (Departamento Nacional da Criança), created by a law of February 17, 1940.[14] Under this law, said to be the result of studies and observations over a period of years,[15] the Bureau is the Federal agency that coordinates all activities in the field of maternal and child welfare. The Bureau's main purpose is indicated in the report to the President accompanying the bill, which, after pointing out Brazil's high infant mortality rate, emphasized the need for a system of complete and effective services for mothers during pregnancy and childbirth and for children from birth to adolescence to assure for them normal conditions of physical, mental, and moral development. The Bureau's task is to stimulate and direct the organization of maternal and child-health and welfare work and to coordinate and supervise child-welfare agencies. The Bureau itself is not expected, at least in the beginning, to organize or conduct local agencies; this task belongs to the States, municipalities, and private agencies. The Bureau will administer Federal aid to the States and municipalities for building maternity homes, children's hospitals, prenatal and child-health centers, and other institutions.

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[9] Serviços Federais de Saúde, em 1937. Relatorio Apresentado . . . pelo. . . . Diretor Geral do Departamento Nacional de Saúde.

[10] *Boletim do Instituto de Puericultura* (Rio de Janeiro), Vol. 2, No. 2 (1939).

[11] *Diario Oficial* (Rio de Janeiro), July 5, 1938.

[12] *Boletín del Instituto Internacional Americano de Protección a la Infancia* (Montevideo), Vol. 14, No. 1 (July 1940).

[13] *Diario Oficial* (Rio de Janeiro), July 5, 1938.

[14] *Diario Oficial* (Rio de Janeiro), Feb. 23, 1940, sec. 1.

[15] *Boletim Trimensal do Departamento Nacional da Criança* (Rio de Janeiro), Vol. 1, No. 1 (June 1940).

Each State of Brazil and the Federal District must organize a system of services for mothers and children under the direction of a special administrative body which is to stimulate and coordinate the work of the municipalities and private agencies in that State and maintain contact with the National Bureau.

In each municipality a special committee of men and women (junta municipal), appointed by the prefect to serve without remuneration, will study methods of organizing local work and will act in individual cases needing attention.

The Bureau, facing this complexity of assignments in a vast, sparsely populated country with great diversity of local conditions, has selected for its beginning the problem considered most urgent; namely, reduction of maternal and infant mortality. To this end the Bureau has decided to encourage the establishment throughout the country of small maternity homes with well-qualified staffs, and of additional health centers for expectant mothers and young children, with facilities for regular examinations by physicians, for the distribution of milk for babies, and for instruction of mothers in the care of their children and themselves. At present such centers exist only in the more important cities of Brazil for care of children from birth to the age of 6 or 7 years; older children are supposed to receive the necessary care from their teachers and school physicians.[16]

The Bureau also plans to attach to the health centers clubs for teaching hygiene and domestic management to mothers and providing recreation for them. All these services, directed by physicians, are to be under the general charge of local women's organizations, financially aided by the municipalities and the Federal Government. This plan, however, is not new in Brazil; more than 200 such organizations have been functioning in the last few years.[17]

The Federal Department of Education and Health, to which the National Children's Bureau is attached, is required to make arrangements with the Federal District and the governors of the States for the organization of the work to be done under this law.

The funds will be appropriated by the Federal Government, the States, and the municipalities; private gifts also will be accepted.

The law creating the National Children's Bureau went into effect on the day of its promulgation, February 17, 1940.

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[16] Oliveira, Olinto de: Postos de Puericultura por Toda Parte. Rio de Janeiro, 1939.

[17] *Boletín del Instituto Internacional Americano de Protección a la Infancia* (Montevideo), Vol. 14, No. 1 (July 1940).

Venezuela Enacts Social-Insurance Law

In compliance with the labor law of Venezuela of 1936, which provided for the introduction of social insurance, a bill was prepared by the staff of the Ministry of Labor in cooperation with the International Labor Office of Geneva. The bill, after revision by a specially appointed committee, became law on July 24, 1940. Under this law, insurance against the risks of illness, maternity, and industrial accidents and diseases is made compulsory for employed persons with an income up to a specified amount. Pending special arrangements, certain groups, chiefly agricultural workers, industrial home workers, and domestic servants are exempt from the provisions of the law.

In case of illness the insured person and members of his family are entitled to medical and surgical care, medicine, and therapeutic appliances. In addition, the insured person receives a daily cash benefit in case of incapacity for work. The maternity benefit consists of obstetric care and a weekly cash payment for 6 weeks before childbirth and 6 weeks afterward.

The insured persons and their employers are required to pay premiums into the insurance fund. The amount of these premiums will be specified in later regulations. The employers are prohibited from using the premiums as an excuse for lowering wages. The expenses in connection with the administration of this law will be met by an appropriation from the National Treasury.

The law will be put into operation gradually in separate localities or separate industries. The insurance becomes operative within 6 months after the President of the Republic makes the law applicable in a locality or industry.

Gaceta Oficial (Caracas), July 24, 1940.

Mexico Introduces Cottage System

The cottage system has been introduced recently in the institutions for dependent children in Mexico City. By order of the Secretary of Public Welfare a special division was established in the Bureau of Public Welfare to direct the work of organizing the cottages. In the first month following this order 5 cottages were opened with accommodations for 140 children from Mexico City. Most of the children had been found begging in the streets and had no families. Despite the short time, the work of the cottages has been found so useful that the Secretary of Public Welfare has ordered the building of 10 additional cottages.

Noticias de la Oficina de Información Obrera y Social (Washington), August 1940; Acción Social (Mexico City), April 15, 1940.

BOOK NOTES

The British Social Services, by Arthur David Kemp Owen. Longmans, Green & Co., London and New York, 1940. 48 pp.

In the words of the author, "The war has confronted the education authorities of Great Britain with some extraordinarily difficult problems. Many thousands of children have been transferred from areas considered vulnerable to air attack to safer areas all over the country. Hundreds of school buildings have been commandeered for war purposes, and the need to provide some protection against the effects of aerial bombardment has made it necessary for hundreds of others to be closed temporarily. The building of new schools to replace unsuitable old school premises has ceased for the time being. . . .

"Some of the developments which are taking place in response to wartime needs have a more than temporary significance. An interesting byproduct of the arrangements for evacuating school children from dangerous districts to safer areas has been the provision of a considerable number of 'evacuation camps' designed for use as school children's holiday camps when the war is over . . . The creation of a National Youth Council and a host of local organizations for looking after the welfare of young people between the ages of 14 and 18 during the war has already opened up many lines of development which promise to be of permanent value. . . ."

Thirty-one evacuation camps had been completed at the time when the book was written.

• ***BIRTH*** •

• ***GROWTH*** •

• ***CHILD HEALTH*** •

Birth Weight and Its Relation to Neonatal Mortality

An Analysis of Data on Live Births in New York City in 1939

By Thomas J. Duffield, S. B., Sylvia L. Parker, Ph. D., and Leona Baumgartner, M .D.[1]

An infant's chance of surviving the critical first month of life is influenced enormously by birth weight in relation to race, sex, and plurality of birth. This is shown by a study of approximately 100,000 live-birth certificates recorded in New York City in 1939.[2] The study utilizes the data obtained through the new supplementary form for the reporting of medical facts on the back of live-birth and stillbirth certificates, which opens up a wealth of new information for the use of health administrators in attacking further the problem of infant and maternal mortality.

In 1934 Dr. Charles F. Bolduan secured the addition of a question regarding the mode of delivery to the birth certificate used in New York City. The attendants at birth were very willing to supply this information, and certain tabulations of the data so obtained were published in the Quarterly Bulletin of the New York City Department of Health in 1934.

In 1934 the Commissioner of Health of New York City appointed an Advisory Obstetric Council, which has been actively cooperating with the city health department ever since.[3]

In 1938 the senior author of this paper, with the assistance of the Advisory Obstetric Council, devised a supplementary form for the reporting of medical facts to be printed on the back of each certificate of live birth [4] and fetal death (stillbirth). By an amendment of the Sanitary Code, effective January 1, 1939, the board of health made the completion of this supplementary medical report compulsory. A copy of the back of a live-birth certificate is shown in figure 1.

The word "confidential" is printed at the top, and below it appears the statement "only for scientific purposes approved by the Board of Health." This arrangement makes it possible to supply photographic reproductions of the face of the certificate, for which requests are often received, without disclosing the information on the back, which the physician furnishes on the understanding that it will be treated as confidential.

The department of health has been very much gratified at the response and cooperation on the part of physicians and hospitals. In 1939, the first year when the supplementary report was compulsory, all the questions were answered satisfactorily on more than 90 percent of the 102,261 live-birth certificates filed in the City of New York. By means of follow-up letters this percentage was increased ultimately to approximately 97 percent for each of the questions.

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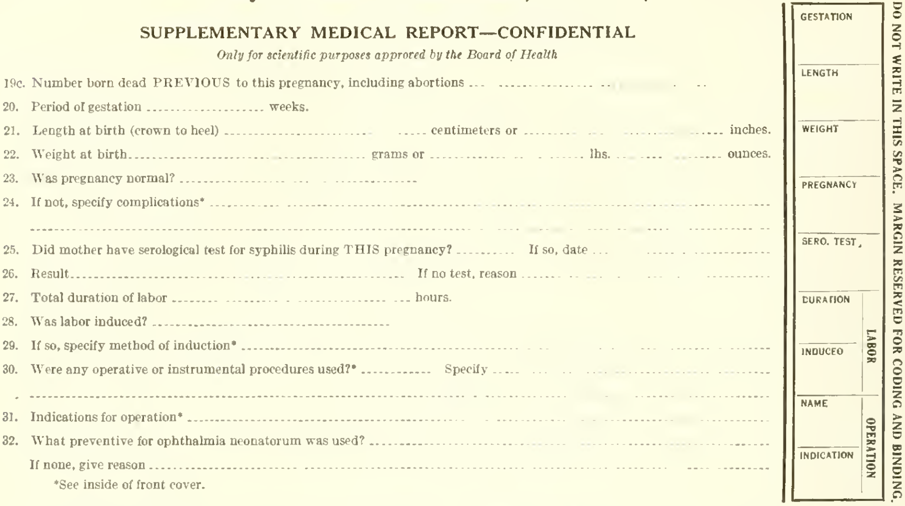
[1] Registrar of records, New York City Department of Health; senior statistician, New York City Department of Health; and district health officer, Kips Bay—Yorkville Health Center, respectively.

[2] This study was made possible by funds allotted by the Children's Bureau under the Social Security Act to the Division of Maternity, Infancy, and Child Hygiene of the New York State Department of Health and by an allotment from the Commonwealth Fund.

[3] The membership of this council is representative of the leading obstetricians from the five boroughs of the city. In 1937 a city-wide committee on prematurity was organized, composed of representative obstetricians and pediatricians, which has worked closely with the hospitals and the department of health. During 1938 and 1939 special infant-mortality committees of the several county medical societies were organized and began intensive studies, using supplementary questionnaires, of all infant deaths under 10 days of age and stillbirths of 28 weeks or more gestation.

[4] "A child is deemed to have been born alive if there was a sign of life such as respiration, heart beat, or movement of voluntary muscle, after complete separation of the body of the child (head, trunk, and limbs) from the body of the mother, notwithstanding whether the cord was or was not cut or the placenta was or was not removed."

Figure 1.—Back of Live-Birth Certificate, New York City



SUPPLEMENTARY MEDICAL REPORT—CONFIDENTIAL

Only for scientific purposes approved by the Board of Health

19c. Number born dead PREVIOUS to this pregnancy, including abortions ……………

20. Period of gestation ……………… weeks.

21. Length at birth (crown to heel) ……………… centimeters or ……………… inches.

22. Weight at birth ……………… grams or ……………… lbs. ……………… ounces.

23. Was pregnancy normal? ………………

24. If not, specify complications* ………………

25. Did mother have serological test for syphilis during THIS pregnancy? ……… If so, date ………

26. Result ……………… If no test, reason ………………

27. Total duration of labor ……………… hours.

28. Was labor induced? ………………

29. If so, specify method of induction* ………………

30. Were any operative or instrumental procedures used?* ……… Specify ………………

31. Indications for operation* ………………

32. What preventive for ophthalmia neonatorum was used? ………………

If none, give reason ………………

*See inside of front cover.

GESTATION

LENGTH

WEIGHT

PREGNANCY

SERO. TEST

LABOR: DURATION

LABOR: INDUCED

OPERATION: NAME

OPERATION: INDICATION

DO NOT WRITE IN THIS SPACE. MARGIN RESERVED FOR CODING AND BINDING.

To facilitate current analyses of these data and their relation to mortality or survival of infants, a system was put into operation at the beginning of 1939 whereby for every infant who dies under 1 month of age, the place, age, and cause of death are transferred mechanically from the death card to unused columns of the birth card. With this system survival rates, as affected by various obstetric factors and correlations of the facts of death with the circumstances of birth, can be studied *currently*. Hitherto only occasional special studies of this nature have been possible.

For 1939, therefore, for the first time, an extensive body of reasonably complete medical information is available for all the live births in New York City, including such items as weight and length of infant, complications of pregnancy, result of serologic test for syphilis, induction of labor, duration of labor, operative procedures (if any), and indications for operation.

Description of the Study

During 1939 in New York City live-birth certificates were filed for 102,261 infants. Of these infants 94,461 (92.4 percent) were white and 7,800 (7.6 percent), Negro and other colored.[5]

The weight at birth was recorded on 97.5 percent of the certificates filed (97.6 percent of the white, 96.8 percent of the colored.)[6]

Birth Weight in Relation to Race, Sex, and Plurality of Birth

In tables 1a and 1b are presented data for each sex showing the distributions of live births, deaths under 1 month of age, and deaths under 1 day of age, by 500-gram weight classes, with subtotals for the group weighing less than 2,500 grams (approximately 5½ pounds)

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[5] Includes 7,608 Negroes, 181 Orientals, and 11 Indians.

[6] Examination of the period of gestation and mortality in the group of infants of unknown weight indicates that these infants (2.5 percent of the total) were not a random sample nor representative of the entire group of births. The unweighed infants had shorter periods of gestation and higher mortality rates than the weighed infants, and therefore this group evidently contained more underweight infants than the weighed group. However, by assuming extremes of the possible weight distributions for the unweighed infants, it is found that the maximum possible effect on incidence and mortality rates would be to increase each of them by something less than 10 percent. In this preliminary report the analyses are based on the records of 99,700 infants born alive whose birth weight was known (92,149 white infants, 7,551 Negro and other colored).

Table 1a.—*Male infants: Live births and deaths under 1 month and under 1 day of age, by weight at birth, plurality of birth, and race; New York City, 1939*

Birth weight (in grams)	Single-born infants						Plural-born infants					
	White			Negro and other colored			White			Negro		
	Live births	Infant deaths		Live births	Infant deaths		Live births	Infant deaths		Live births	Infant deaths	
		Under 1 month	Under 1 day		Under 1 month	Under 1 day		Under 1 month	Under 1 day		Under 1 month	Under 1 day
Total	47,781	1,169	636	[1] 3,847	151	84	919	122	76	95	15	8
Weight stated	46,574	1,083	577	3,719	131	67	885	108	70	90	15	8
Less than 2,500	2,504	566	375	320	88	55	457	98	66	56	15	8
Less than 1,000	150	144	126	20	19	17	21	20	19	5	5	5
1,000-1,499	202	145	95	40	35	27	47	29	18	7	5	2
1,500-1,999	411	133	78	56	13	2	127	34	21	13	2	...
2,000-2,499	1,741	144	76	204	21	9	262	15	8	31	3	1
2,500 or more	44,070	517	202	3,399	43	12	428	10	4	34	...	...
2,500-2,999	7,143	159	62	881	14	5	246	7	3	25	...	...
3,000-3,499	17,840	176	70	1,440	15	4	143	3	1	7	...	...
3,500-3,999	13,652	109	34	820	10	1	35	...	...	1	...	...
4,000-4,499	4,459	52	26	222	3	2	4	...	...	1	...	...
4,500-4,999	852	18	8	32	1	...	...	...	...	...	...	...
5,000 or more	124	3	2	4	...	...	...	...	...	...	...	...
Weight not stated	1,207	86	59	128	20	17	34	14	6	5	...	...

[1] Includes 3,746 Negro, 74 Chinese, 22 Japanese, and 5 Indian infants.

Table 1b.—*Female infants: Live births and deaths under 1 month and under 1 day of age, by weight at birth, plurality of birth, and race; New York, 1939*

Birth weight (in grams)	Single-born infants						Plural-born infants					
	White			Negro and other colored			White			Negro		
	Live births	Infant deaths		Live births	Infant deaths		Live births	Infant deaths		Live births	Infant deaths	
		Under 1 month	Under 1 day		Under 1 month	Under 1 day		Under 1 month	Under 1 day		Under 1 month	Under 1 day
Total	44,811	787	394	[1] 3,792	110	60	950	119	66	66	8	4
Weight stated	43,757	735	365	3,683	99	52	933	111	61	59	7	4
Less than 2,500	2,876	396	246	475	70	41	572	101	57	31	7	4
Less than 1,000	120	106	86	21	20	17	30	28	26	3	2	2
1,000-1,499	185	112	75	40	18	8	53	28	16	8	4	2
1,500-1,999	453	94	50	97	17	8	162	24	8	7	1	...
2,000-2,499	2,118	84	35	317	15	8	327	21	7	13	...	...
2,500 or more	40,881	339	119	3,208	29	11	361	10	4	28	...	...
2,500-2,999	9,144	118	45	1,037	10	3	257	7	3	22	...	...
3,000-3,499	18,207	120	34	1,441	9	4	85	3	1	4	...	...
3,500-3,999	10,462	65	24	587	10	4	18	...	...	2	...	...
4,000-4,499	2,638	31	14	120	...	...	1	...	...	...	...	...
4,500-4,999	372	4	1	18	...	...	...	...	...	...	...	...
5,000 or more	58	1	1	5	...	...	...	...	...	...	...	...
Weight not stated	1,054	52	29	109	11	8	17	8	5	7	1	4

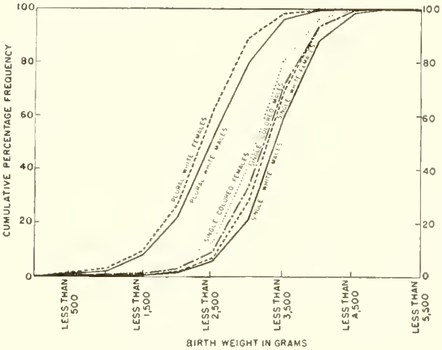
[1] Includes 3,701 Negro, 75 Chinese, 10 Japanese, and 6 Indian infants.

and the group 2,500 grams or more, by plurality of birth and race.

The distributions for infants of races other than white are, as indicated in the footnotes to the tables, predominantly for Negro infants. The very small numbers of Orientals and Indians do not allow separate analyses. Since exclusion of these small numbers of Orientals and Indians makes no perceptible difference in any of the results or conclusions, the following analysis treats the Negro and other colored races together.

Cumulative percentage distributions of the several groups of live births by weight at birth are plotted in figure 2. This shows the cumulative percentage frequency distributions of birth weights by 500-gram weight groups for male and female, white and colored, and single- and plural-born infants.

Figure 2.—Cumulative Percentage Frequency Distribution of Live Births by Weight Groups, New York City, 1939



The curves are of especial interest in relation to the use of birth weight as a criterion of prematurity. If a birth weight of less than 2,500 grams (5½ pounds) is taken in hospital practice as the sole indication for prescribing special care, there result wide differences in the percentages of male and female infants, white and colored infants, and single- and plural-born infants receiving such care. For example, 61 percent of plural-born white female infants weighed less than 2,500 grams compared with 7 percent of single-born white females. Fifty-two percent of plural-born white males weighed less than 2,500 grams compared with 5 percent of single-born white males. It has been pointed out by Dunham et al[7] that when birth weight alone is taken as a criterion of prematurity, more colored infants than white and more female than male infants of both races will be considered premature. Data from the New York City study relating to other evidences of maturity such as crown-heel length of the infant and period of gestation will be discussed in a later report.

BIRTH WEIGHT AND MORTALITY BY SEX, PLURALITY OF BIRTH, AND RACE

Mortality rates for infants under 1 month of age and under 1 day of age are presented in tables 2 and 3 and plotted in figures 3 to 6.

Neonatal Mortality.[8]

Figure 3 gives the neonatal mortality rates of males, with separate curves by weight at birth for single-born white infants, single-born colored infants, and plural-born white infants. Figure 4 shows the corresponding curves for females.

TABLE 2.—*Neonatal mortality rates*[1] *of male and female infants, by weight at birth, plurality of birth, and race; New York City, 1939*

Birth weight (in grams)	Mortality rates					
	Male			Female		
	Single-born		Plural-born	Single-born		Plural born
	White	Negro and other colored	White	White	Negro and other colored	White
Total	24	39	133	18	29	125
Weight stated	23	35	122	17	27	119
Less than 2,500	226	275	214	138	147	177
Less than 1,000	960	950	952	883	952	933
1,000–1,499	718	875	617	605	450	528
1,500–1,999	324	232	268	208	175	148
2,000–2,499	83	103	57	40	47	64
2,500 or more	12	13	23	8	9	28
2,500–2,999	22	16	28	13	10	27
3,000–3,499	10	10	21	7	6	35
3,500–3,999	8	12	------	6	17	-------
4,000–4,499	12	14	-------	12	--------	-------
4,500–4,999	21	31	-------	11	--------	-------
5,000 or more	24	-------	-------	17	--------	-------
Weight not stated	71	156	412	49	101	471

[1] Deaths under 1 month of age per 1,000 live births.

Examination of tables 2 and 3 and figures 3 and 4 reveals in each curve an enormous drop in neonatal mortality rates with increase in birth weight up to about 2,250 grams, followed by a comparatively flat succession of minimum mortality rates up to about 3,750 grams, when an increase in mortality rates occurs at the end of each curve. All six curves (figs. 3 and 4)

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[7] Dunham, E. C., R. Jenss, and A. Christie: A Consideration of Race and Sex in Relation to the Growth and Development of Infants. *Journal of Pediatrics*, vol. 14 (February 1939), pp. 156–160.

[8] Deaths under 1 month of age

Figure 3.—Mortality Rates of Male Infants Under 1 Month of Age; New York City, 1939

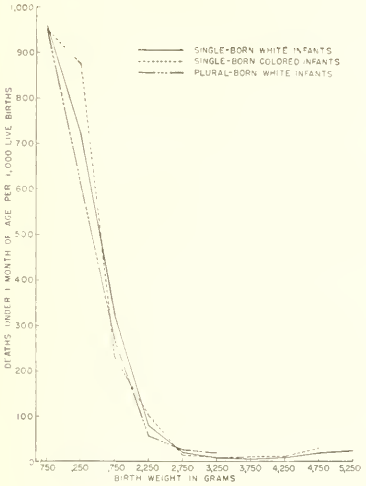


Figure 5.—Mortality Rates of Male Infants Under 1 Day of Age; New York City, 1939

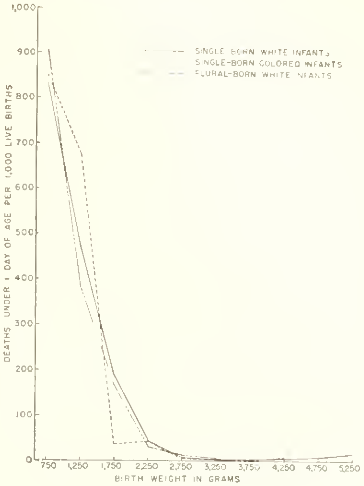


Figure 4.—Mortality Rates of Female Infants Under 1 Month of Age; New York City, 1939

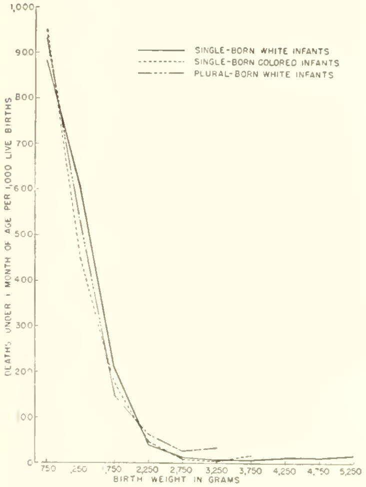
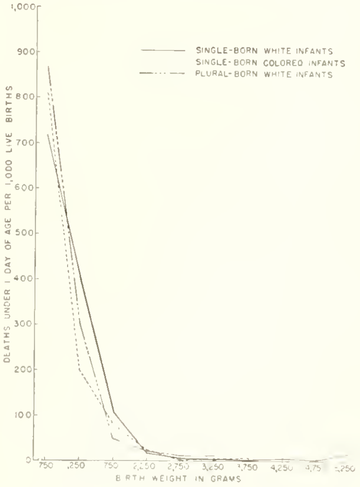


Figure 6.—Mortality Rates of Female Infants Under 1 Day of Age; New York City, 1939



of neonatal mortality rates by weight at birth show substantially the same trend.

As is shown in tables 2 and 3, mortality rates are uniformly and consistently somewhat lower for single-born white female infants than for single-born white male infants in all the birth-weight groups up to about 4,000 grams and are lower for single-born colored females than for single-born colored males in almost all the lower weight groups.

Table 3.—*Mortality rates*[1] *of male and female infants under 1 day of age by weight at birth, plurality of birth, and race; New York City, 1939*

Birth weight (in grams)	Mortality rates					
	Male			Female		
	Single-born		Plural-born	Single-born		Plural born
	White	Negro and other colored	White	White	Negro and other colored	White
Total	13	22	83	9	16	69
Weight stated	12	18	79	8	14	65
Less than 2,500	150	172	144	86	86	100
Less than 1,000	834	850	905	717	810	867
1,000–1,499	470	675	383	405	200	302
1,500–1,999	190	36	165	110	82	49
2,000–2,499	44	44	31	17	25	21
2,500 or more	5	4	9	3	3	11
2,500–2,999	9	6	12	5	3	12
3,000–3,499	4	3	7	2	3	12
3,500–3,999	2	1	------	2	7	------
4,000–4,499	6	9	------	5	------	------
4,500–4,999	9	------	------	3	------	------
5,000 or more	16	------	------	17	------	------
Weight not stated	49	133	177	28	73	294

[1] Deaths per 1,000 live births.

There are no uniform or consistent differences, on the other hand, between the mortality rates of single-born white and single-born colored infants of the same sex having the same weight at birth. It appears that the higher neonatal mortality rate of the total group of single-born colored males (39 per 1,000 live births) compared with that of single-born white males (24) can be accounted for by the larger percentage of small infants among the single-born colored (table 4). Similarly, the higher neonatal mortality rate of the total group of single-born colored females (29 per 1,000 live births) compared with that of single-born white females (18) can be accounted for by the larger percentage of smaller infants among the single-born colored.

Table 4.—*Incidence of underweight among infants in single and plural live births, by sex and race; New York City, 1939*

Plurality of birth, sex, and race	Live births		
	Total	Birth weight less than 2,500 grams	
		Number	Percent
Total with weight stated	99, 700	7, 290	7. 3
Single-born infants:			
White males	46, 574	2, 504	5. 4
White females	43, 757	2, 876	6. 6
Colored males	3, 719	320	8. 6
Colored females	3, 683	475	12. 9
Plural-born infants:			
White males	885	457	51. 6
White females	933	572	61. 3
Colored males	90	56	62. 2
Colored females	59	31	52. 5

Neither are there any uniform or consistent differences between the mortality rates of single-born white infants and plural-born white infants of the same weight at birth. The higher neonatal mortality rate of the total groups of plural-born white males (133 per 1,000 live births) compared with that of single-born white males (24) can be accounted for by the very much greater percentage of small infants among the plural-born white males. Likewise, the higher mortality rate of the total group of plural-born white females (125 per 1,000 live births) compared with that of single-born white females (18) can be accounted for by the very much greater percentage of small infants among the plural-born white females (table 4).

Mortality Under 1 Day of Age.

It is a well-recognized fact that reduction in the mortality during the first month of life has not kept pace with reduction in mortality during the remainder of the first year of life. It is not so generally realized that the mortality of the *first day* of life has shown practically no decrease in the last 25 years—and actually no decrease in New York City either among white or among colored infants. These deaths now constitute about one-third of all deaths during the first year of life in New York City.

It is, therefore, of particular interest to focus attention upon the mortality during the first day of life. Figure 5 presents the mortality rates under 1 day of age by weight at birth, for single-born white males, single-born colored males, and plural-born white males. Figure 6 presents the corresponding curves for females. Examination of these figures leads to exactly the same conclusions derived from the mortality rates under 1 month of age.

In conclusion, since in the same birth-weight groups no consistent, uniform difference can be demonstrated between the neonatal mortality rates of white and colored infants, the higher crude mortality rates of colored infants in comparison with white infants can be attributed to the lower birth weights of the colored infants. Similarly, the higher mortality of infants born of multiple pregnancies can be accounted for by the lower birth weights of such infants.

Weight at birth is the criterion in general administrative use for prematurity. In addition to the high mortality rates of premature infants the special care for such infants involves almost prohibitive expense. It is apparent that more attention should be focused on determining the causes of premature births and measures for their prevention.

Maternal Welfare in Philadelphia

By Ruth Hartley Weaver, M. D.

Recorder, Committee on Maternal Welfare, Philadelphia County Medical Society

Until recently, Philadelphia had a stationary maternal mortality rate and a gradually declining birth rate. Because of this, a study of every maternal death occurring in the city was undertaken. The Philadelphia County Medical Society appointed the Committee on Maternal Welfare under the competent leadership of Dr. Philip F. Williams, and a study of maternal deaths was begun in 1931.

The study was patterned after that of the New York Academy of Medicine. Complete data were obtained on each death directly from the hospital records, also by personal interviews with the attending physician or midwife, and, if necessary, by consulting the family. The data were tabulated on a monthly basis. Each death occurring in the previous month was reviewed at a monthly meeting of qualified obstetricians who discussed the cases impartially and impersonally. The primary objective of this study was to find out why so many Philadelphia mothers lost their lives from conditions of pregnancy and childbirth and what could be done to save them.

When the study had been under way 3 years a report was issued.[1] This report showed that there were four major problems to be considered in Philadelphia:

1. Self-induced and criminal abortions.
2. Errors in judgment on the part of physicians.
3. Lack of appreciation by the laity of the need for adequate prenatal care.
4. Failure of hospitals, organized medicine, and allied agencies to grasp fully their responsibilities and opportunities.

It was decided to continue the study and to work to correct these conditions. An educational campaign was inaugurated for both the medical profession and the laity. A series of articles dealing with various phases of maternal mortality appeared from time to time in the *Weekly Roster and Medical Digest*, the official publication of the Philadelphia County Medical Society. A circular letter was sent to each hospital urging the staff to discuss the subject of maternal mortality at their meetings. This same request was presented to all the clinical medical societies and branch and affiliated organizations throughout the city. There was a generous response from these appeals. Qualified speakers were sent to hospitals in various sections of the city to conduct symposia on special phases of the problems concerned in maternity care. These meetings were planned for the benefit of local physicians who for one reason or another were unable to attend medical gatherings outside their own neighborhoods. Lay organizations of all types were sent qualified medical speakers to present the subject, "What Constitutes Adequate Maternity Care?" Ministers were asked to include in their Mothers' Day program some reference to the needs of the expectant mother for adequate maternity care. By methods such as these information was circulated widely to both the medical profession and the laity.

Efforts were made, too, to improve hospital obstetric practice. Hospital superintendents were advised of the requirements for maintaining adequate maternity facilities. Obstetric staff conferences were recommended for the purpose of having open discussion on morbidity and mortality. These conferences are conducted now in almost every institution caring for obstetric cases. To them are invited not only the regular staff members but also the courtesy staff. Uniform courtesy-staff regulations for every hospital were recommended, which would result in the granting of operative privileges only to physicians properly qualified to operate. These were well received and were adopted by nearly every hospital.

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[1] Maternal Mortality in Philadelphia, 1931–33. Philadelphia, 1934.

The committee was enlarged to include the junior members on the obstetric staff. These men and women serve entirely without compensation and are most conscientious in their attendance at the monthly meetings as well as in working up their case reports. We are fortunate in still having Dr. Philip F. Williams as the chairman. He has been our guide and inspiration for the past 10 years.

The committee members act as liaison officers between the Committee on Maternal Welfare and the various hospitals. They take back to their own institutions whatever suggestions and recommendations are made and are instrumental in seeing that adequate regulations are carried out in their hospitals.

Review of the figures for the 9 years in which the study has been under way shows what has been accomplished and where efforts must still be directed. The following table shows primary cause of death as determined by the study for deaths that the physician mentioned as associated with pregnancy and childbirth. The data are presented in 3-year periods for comparison:

Maternal Mortality in Philadelphia, 1931–39

Cause of death	Number of deaths			Rate per 10,000 live births		
	1931–33	1934–36	1937–39	1931–33	1934–36	1937–39
Total	717	590	385			
Obstetric causes	639	494	302	66.9	55.2	33.1
Septic abortion	160	146	85	16.7	16.3	9.3
Abortion, no mention of sepsis	24	8	3	2.5	.8	.3
Extrauterine pregnancy	32	30	20	3.3	3.3	2.1
Other accidents of pregnancy	0	2	0		.2	
Hemorrhage of pregnancy	63	53	37	6.6	5.9	4.0
Puerperal septicemia	121	115	54	12.6	12.8	5.9
Albuminuria and eclampsia	88	57	46	9.2	6.3	5.0
Vomiting of pregnancy	22	13	9	2.3	1.4	.9
Embolus and sudden death	44	17	14	4.6	1.9	1.5
Other accidents of childbirth	85	53	34	8.8	5.9	3.7
Nonobstetric causes	78	96	83			

PRIMARY CAUSE OF DEATH

Septic Abortions.

The death rate from septic abortion remained practically the same in the first two periods but dropped 44 percent by the third period. This suggests better economic conditions, as most of the criminal abortions occurred among married women, many of whom had several living children. Wider use of contraceptives may also have had some influence. In addition, this decrease reflects the prolonged and intensive efforts that have been made to promote more conservative handling of abortions. Conservative methods include the avoidance of intrauterine instrumentation in the presence of fever; the giving of blood transfusions; and the administration of sulfanilamide and allied compounds.

Hemorrhage.

The death rate from hemorrhage was only slightly lower in the second period of the study but by the third period it had decreased nearly 40 percent. This is due to a keener appreciation on the part of both the patient and the physician of the dangers of antepartum bleeding, to more widespread use of blood transfusions in the treatment of all types of hemorrhage, and to the hospital practice of permitting only skilled physicians to perform certain kinds of obstetric operations.

Septicemia.

The death rate from septicemia was practically the same in the first two periods studied.

but by the third it had dropped 53 percent. This is due in no small measure to a general tightening of the techniques of service in the delivery room. Four factors have been prominent in reducing deaths from sepsis:

1. The discussion in obstetric staff conferences of all septic cases has led to a greater degree of "aseptic conscience" among the members. Free and open discussion of the etiology, prevention, and treatment of septicemia has brought this subject prominently before the medical profession. It is a matter of personal pride on the part of the staff of every hospital that septic deaths be held to a minimum.

2. The hospital practice of permitting only skilled physicians to perform operations, and adoption of courtesy-staff regulations have reduced the number of unnecessary or ill-advised operations.

3. Regulations introduced by the director of public health as to the management of obstetric departments of hospitals have been most effective.

4. The more widespread use of blood transfusions and of sulfanilamide and its compounds and more frequent consultations have greatly decreased the number of deaths from septicemia.

Toxemia.

The death rate from toxemias of pregnancy (albuminuria and eclampsia and vomiting of pregnancy) has shown a steady decline since the beginning of the study. It was 33 percent less in the second period than in the first and 23 percent less in the third period than in the second. The total drop amounts to 49 percent. This improvement has been due to greater appreciation by both the medical profession and the laity of the seriousness of the early signs of toxemia. Physicians have come to realize that the earliest signs require hospitalization and consultation. There has been almost universal adoption of the practice of sending a pregnant woman to the hospital if she has a blood pressure of 130–90 or a rise of 20 points over the preceding reading, in either the systolic or diastolic pressure, a light cloud of albumin in her urine, an unusual weight gain even when no other symptoms are present, or any other clinical symptoms of early toxemia. The public has had continued education which is invaluable in prophylaxis of toxemia. Prospective mothers have been instructed in classes and clinics in the various hospitals as to the causes of toxemia, the danger signals, and the means of prevention. Prospective fathers have been instructed in classes taught by members of the Philadelphia County Medical Society. Here frank discussion has been most helpful.

Embolus and Sudden Death.

The greatest improvement of all has been made in the deaths classified under embolus and sudden death. A total decrease of 67 percent has taken place in the death rate, most of which had occurred by the end of the second period.

Some of this decrease may be due to more accurate reporting of the exact cause of death. In former years death was frequently attributed to embolus when actually it was caused by postpartum hemorrhage, rupture of the uterus or other accidents, or even by heart disease. Today, with more accurate information, this rather indefinite cause of death is appearing less commonly.

However, there has also been a real reduction in deaths due to embolus as an increasing number of women are being delivered in more suitable surroundings—more than 85 percent in hospitals and maternity institutions. Staff organizations have advanced to a degree where they can bring to a successful conclusion many cases that formerly might have ended in catastrophe. They also use more care in the selection of the type of analgesia and anesthesia and refuse to grant operative privileges to physicians who are not properly qualified to operate. These advances on the part of the medical profession have lessened the number of deaths in this group.

Other Accidents of Childbirth.

Deaths due to other accidents of childbirth, including Cesarean section, other forms of operative delivery, and difficult labor in general, have shown a marked decline in each 3-year period of the study. There was a drop in the rate of 33 percent in the second period over the first and a drop of 37 percent in the third period over the second. The total reduction of 58 per cent was exceeded only by the decrease in deaths from embolus. This decrease was due largely to more adequate study of prenatal cases by physicians, especially of multigravidae with a history of operative delivery, stillbirth, or death of a child in the neonatal period. More attention is being paid to evidences of disproportion between the fetus and the pelvis. In short, improvement in this class of cases has resulted from having only properly qualified personnel perform obstetric surgery and from critical analysis in staff conferences of the indications for interference with the normal processes of delivery.

The puerperal death rate in Philadelphia has declined from 66.9[2] per 10,000 live births at the beginning of the study to 33.1[3] in 1939, but further reduction is possible. Today there are three leading causes of death—sepsis, toxemia, and hemorrhage.

METHODS OF PREVENTION

What can be done to prevent deaths from sepsis?

1. Avoid abortions!

Early registration of every prenatal patient will permit competent handling of her social, physical, and financial needs, so that she will not resort to criminal abortion.

More widespread instruction in birth control is needed.

More competent handling of septic-abortion cases is essential. The uterus should not be entered except to remove material for better drainage or for the control of hemorrhage. Sulphanilamide or its compounds should be administered and transfusions used more frequently.

2. Close every avenue of infection.

An eroded cervix or chronic vaginitis should be treated appropriately early in pregnancy. Sexual intercourse should be prohibited in the last trimester of pregnancy.

Every parturient woman should be regarded as hypersusceptible to infection during her labor and delivery. Physicians and nurses should maintain strict cleanliness in technique. Every death from septicemia should be the occasion for a close clinical and bacteriological investigation of all personnel and supplies connected with the delivery.

What can be done to prevent deaths due to toxemias?

Every prenatal patient should have adequate care from the beginning of pregnancy and should be taught the hygiene of pregnancy and the significance of even minor degrees of toxemia.

Toxic patients should be hospitalized for study and observation as soon as the symptoms are noted. Any woman who has once shown signs of toxemia should be viewed as a special risk and should have continued follow-up study to determine whether she should have more children.

What can be done to prevent deaths from hemorrhage?

1. Early diagnosis should be made of ectopic pregnancies.

Every pregnant woman should be examined by a competent physician early in pregnancy to see that the fetus is not situated outside the uterus.

Any abdominal pain in a woman who has missed her menstrual period should be regarded with suspicion as pointing to ectopic pregnancy until proven otherwise, and a consultant should be called. If the diagnosis is doubtful an exploratory laparotomy, which is considered conservative treatment under such circumstances, should be performed.

2. Earlier diagnosis should be made of placenta previa and premature separation.

Lay education should be extended to include the significance and the danger of antepartum hemorrhage so that placenta previa and premature separation may be recognized earlier and treated more promptly and efficiently.

The danger of premature separation should always be borne in mind in the presence of signs of toxemia.

3. Conditions that predispose to postpartum hemorrhage should be guarded against. These

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[2] Figures for 1931 furnished by U. S. Bureau of the Census.

[3] Figures for 1939 furnished by the Committee on Maternal Welfare as Bureau of the Census figures are not available for 1939.

include uterine inertia, prolonged labor, too deep analgesia and anesthesia, and improper handling of the third stage of labor.

More frequent and earlier use of intrauterine packing in the third stage of labor and replacement of fluid and blood are essential adjuvants.

The work of the Committee on Maternal Welfare in Philadelphia has been far-reaching. It began as a study of puerperal mortality. It expanded to embrace an educational program for physicians, laity, and hospital administrators. As a result of its efforts, studies were begun of infant mortality. Two new committees were formed—the Committee on Stillbirths[4] and the Committee for the Study of Neonatal Deaths.[5] They are functioning actively. As the largest single cause of infant mortality is prematurity, a new study is being considered to determine the causes and methods of preventing premature birth. Philadelphia is now analyzing every phase of its mortality connected with pregnancy and childbirth. With the enthusiasm and cooperation of all concerned, future progress is insured.

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[4] *See* An Analysis of 1,000 Consecutive Stillbirths in Philadelphia, by Thaddeus L. Montgomery, M. D. *The Child,* Vol. 4, No. 3 (September 1939).

[5] *See* Preliminary Report on the Study of Neonatal Deaths in Philadelphia, by Ralph M. Tyson, M. D. *The Child,* Vol. 3, No. 9 (March 1939).

Babies and the Defense Boom[1]

The moving of workers and their families to centers where defense industries are booming is causing some headaches among public health people. There are housing, sanitation, transportation, and schooling problems—and, too, there are problems which have to do with the coming of babies.

Many of the defense workers are young people. They are in the childbearing age. Moving to a new community means that they are unfamiliar with the local facilities for the care of mothers and babies. This unfamiliarity may lead to delay in seeking care. Delay may mean the development of preventable complications that menace the life and health of mothers and babies. Too, facilities for maternity care in these defense-industry communities may not be geared to a sudden influx of expectant mothers. During the depression, hospitals in many industrial towns suffered from lack of funds and public support, and they have never recovered from this financial anemia which has meant inability to provide really good maternity care. Or there may never have been good hospitals for the care of mothers and babies. The sudden spurt of production and the influx of new residents puts an even greater burden upon the already inadequate facilities.

Then there is the serious problem in these booming towns of unwanted children. New surroundings, unsettled housing, desire among the women folks to work—all these play a part in the tragic predicament of the unwanted child. Criminal abortions may increase, with their resulting scars on the moral as well as the physical fiber of the women who decide upon such a course.

This is an important-enough problem of national morale to call for action. We suggest the formation in each community affected by defense-boom conditions, of a committee of professional and civic-minded citizens. The task of this committee would be threefold.

It should consider all phases of community life that have a direct bearing on maternity—including housing, medical, nursing, and hospital facilities. It should take a leading part in all efforts to improve living conditions and professional care to mothers and babies. For instance, if adequate hospital delivery service is not possible, then some scheme should be worked out for the care of mothers in their own homes.

The committee should serve as a clearing house for those unfamiliar with local maternity care. It should have a list of doctors equipped by training and experience to care safely for mothers; a list of good hospital facilities, free and pay; information about private-duty nurses, visiting-nurse services, and visiting housekeepers.

The committee should teach the public the elements of safe maternity—healthy, contented parents; good home surroundings; and early and continuous medical care; opportunity for the mother to recuperate after the baby comes; good adjustment of the new parents to the baby and the baby to the parents. The problems of abortion and sterility should not be overlooked.

If the international situation should deteriorate, this committee is then in readiness to meet any emergency that might arise in the task of caring for mothers and babies and of preserving family morale at a high peak.

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[1] Quoted from *Briefs* (Maternity Center Association, 654 Madison Ave., New York), November 1940.

Results of an Investigation of the Reporting of Births, Stillbirths, and Infant Deaths

Williamson County, Tenn., 1935–37

By Don C. Peterson, M. D., C. P. H.

Director, Williamson County Health Department, Franklin, Tenn.[1]

Upon publication of the Annual Bulletin of Vital Statistics for 1936 by the Tennessee Department of Public Health it was noted that the infant death rate for Willamson County was high—81.9 per 1,000 live births. There were two reasons for this high rate: First, an increase in the number of infant deaths; and, second, a decrease in the number of reported live births. It was decided to investigate whether or not the number of births reported represented the correct number of births occurring in Williamson County. It was thought that if additional births had occurred and were then reported the infant death rate would be lowered.

It might be pointed out that Williamson County is a typical rural county with one small incorporated town—Franklin, the county seat. This county is located in the central part of Tennessee and has a total population, according to the 1930 census, of 22,845, of which 17,571 (77 percent) were white persons and 5,274 (23 percent) were Negroes. The local full-time health department was established in 1921 and consists of a medical director, a supervisory nurse, three staff nurses, a sanitation officer, and two clerks. In addition to this personnel there are special groups engaged in research work in the fields of tuberculosis and mental hygiene.

For the purposes of this investigation it was decided to include data for 1935, 1936, and 1937 in the study of reporting, as punch cards had been prepared for these years for use in a special study of maternal and infant care being carried on in the Williamson County Health Department. During this period of 3 years the nursing staff had given prenatal supervision to the mothers of 846 infants (48 percent) of the 1,762 births known to have occurred in the county.

The first step in finding unreported births was the matching of all closed maternity records with the birth summary cards. This was done by placing the records together. Records for which no birth summary cards were in the files were segregated, and birth summary cards were prepared and marked as not-registered births. The closed and active files of infant and preschool records were also matched with the birth summary cards. Death summary cards of all infants were also checked to make sure that the births had been registered. Unreported births were found through each of these procedures.

The basic maternity, infant, and preschool records were inspected for information indicating that an infant death or a stillbirth had occurred. By this means a few unreported infant deaths and stillbirths were discovered.

A punch card was then prepared for each live birth and stillbirth for which a record of any type was on file in the Williamson County Health Department. These punch cards were checked with the basic records before the records were refiled.

In addition, visits were made to the physicians and the midwives practicing in the county. Several birth certificates were secured which through oversight had not been sent to the local registrar.

As a few births might have been recorded by the local registrars in the Tennessee Department of Public Health without being routed through the local health department, all births for which no summary cards were on file were checked with records in the Division of Vital Statistics of the Tennessee Department of Public Health. Several births for which summary cards were not on file were found to be registered there.

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[1] Since July 1, 1940, Director, Division of Vital Statistics, Tennessee Department of Public Health, Nashville.

The next step was the preparation for registration of "delayed birth certificates" with the identifying data for all these unreported births. The attendant at each birth, if living and known, was given for signature the certificates of the babies whose births he attended. If the attendant at birth had died, the parents of the child were furnished forms for completion by affidavit.

The results of this work can best be shown by the following tables.

Table 1 shows the numbers of births in the column "Official data" as published in the Tennessee Annual Bulletins of Vital Statistics for the years indicated. Under "Study data" are listed the numbers of births, with rates per 1,000 population, which are known to have occurred in Williamson County and for whom the date, place of birth, parents, race, and sex are known. All data have been corrected for residence. The average annual birth rate in Williamson County from official records was 21.3; the average annual corrected birth rate based on study data was 25.7 per 1,000 population.

TABLE 1.—*Live births and birth rate, as reported officially and as shown by investigation, by years: Williamson County, Tenn., 1935–37*

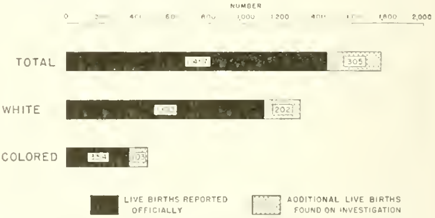
Year	Live births			
	Official data		Study data	
	Number	Rate per 1,000 population	Number	Rate per 1,000 population
Total	1,457		1,762	
1935	493	21.6	600	26.3
1936	415	18.2	536	23.5
1937	549	24.0	626	27.4
Average	486	21.3	587	25.7

In table 2 the totals for the 3 years are presented by race. There are also presented the increases in the number of births and the percentage increase of the study data over the official data. An increase of 305 births (20.9 percent of the total) was obtained through this investigation. When classified as to race an increase was found of 202 births of white infants (18.3 percent), and 103 births of colored infants (29.1 percent). This indicates that relatively the reporting was poorer for the colored than for the white population. These data are presented graphically in the accompanying figure.

TABLE 2.—*Total live births and average annual rate, as reported officially and as shown by investigation, by race; Williamson County, Tenn., 1935–37*

Race	Live births					
	Official data		Study data		Increase	
	Number	Rate per 1,000 population	Number	Rate per 1,000 population	Number	Percent
Total	1,457	21.3	1,762	25.7	305	20.9
White	1,103	20.9	1,305	24.8	202	18.3
Colored	354	22.4	457	28.9	103	29.1

Figure 1.—Live Births Reported Officially and Additional Live Births Found on Investigation, by Race; Williamson County, Tenn., 1935–37



In regard to the attendant at delivery (table 3), it is noted that in this 3-year period 212 births were attended by physicians and were not reported. These 212 unreported births represent an increase of 17.3 percent in the number of births attended by physicians. The number of unreported births attended by midwives and others, although not so large as the number attended by physicians, is very significant. In this group there were 93 unreported births, which is an increase of 39.6 percent in the number of births attended by midwives and others. Of the total live births during the 3-year period 328 (18.6 percent) were attended by midwives and others.

TABLE 3.—*Live births by race and attendant at delivery; number reported officially and number found on investigation, Williamson County, Tenn., 1935–37*

Race, and attendant at delivery	Live births			
	Official data	Study data	Increase	
			Number	Percent
Total	1,457	1,762	305	20.9
Physician	1,222	1,434	212	17.3
Midwife or other	235	328	93	39.6
White	1,103	1,305	202	18.3
Physician	963	1,108	145	15.1
Midwife or other	140	197	57	40.7
Colored	354	457	103	29.1
Physician	259	326	67	25.9
Midwife or other	95	131	36	37.9

In addition to the investigation of birth reporting as outlined the summary cards for infant deaths and stillbirths were checked. In connection with the stillbirth and infant death rates in the following tables it should be taken into consideration that these rates are computed on a different basis. The rates for the official data are computed on the live births reported to the Tennessee Department of Public Health. The rates for the study data are computed on all live births, including those found on investigation.

In table 4 are given the results of the study in regard to the reporting of stillbirths. Fourteen additional stillbirths were found during the investigation; this changed the stillbirth rate from 33.6 to 35.8 per 1,000 live births. The stillbirth rate for colored infants showed a slight decrease, from 62.1 to 59.1 per 1,000 live births. This rate does not in all probability approximate the true stillbirth rate, because it is very difficult to get information concerning stillbirths among rural Negroes.

TABLE 4.—*Total stillbirths and average annual rate, as reported officially and as shown by investigation, by race; Williamson County, Tenn., 1935–37*

Race	Stillbirths			
	Official data		Study data	
	Number	Rate per 1,000 live births	Number	Rate per 1,000 live births
Total	49	33.6	63	35.8
White	27	24.5	36	27.6
Colored	22	62.1	27	59.1

Upon investigation 10 infant deaths were found which had not been reported. Of these 5 were white infants and 5 were colored. When the official infant death rate is compared with the study death rate no significant difference is found. This applies to death rates of the white and the colored infants separately as well as to the total infant death rate. Even the high infant death rate of 1936 was lowered less than had been hoped—from 81.9 to 72.8 per 1,000 live births. The reason for this is that there was a proportionate increase in reporting of both live births and infant deaths.

TABLE 5.—*Total infant deaths and average annual rate, as reported officially and as shown by investigation, by race; Williamson County, Tenn., 1935–37*

Race	Infant deaths			
	Official data		Study data	
	Number	Rate per 1,000 live births	Number	Rate per 1,000 live births
Total	84	57.7	94	53.3
White	57	51.7	62	47.5
Colored	27	76.3	32	70.0

SUMMARY

As a result of an intensive program of searching for unreported births, the number of known births in Williamson County in the 3-year period, 1935–37, was increased 20.9 percent. Of the total of 305 unreported births, 202 were of white infants and 103 were of Negroes. An increase of 18.3 percent was obtained in the number of live births of white infants and 29.1 percent in the number of live births of colored infants. A simultaneous search for unreported stillbirths and infant deaths resulted in a proportionate increase in the number of stillbirths and infant deaths being found. Although there were no significant changes in the stillbirth or infant death rates, the increase in the birth rate was extremely significant.

COMMENT

When the number of unreported births is considered by months it is found that the physicians failed to report some five or six births each month. The midwives neglected to report two or three births each month. These are not large figures, but when allowed to accumulate over a period of years they represent a very significant loss in the completeness of registration.

In order to prevent these small leaks several steps have been taken. First, no maternity record is closed until an appropriate certificate, birth or stillbirth, has been filed. Second, all infant and preschool records are checked against the birth index file by the clerk of the local health department for registration. Third, one of the clerks in the local health department has been appointed local registrar for the entire county. Fourth, all physicians and midwives in the county are asked once a month for a report of the deliveries attended during the month. Fifth, the staff of the local health department has been made acutely aware of the importance of birth reporting and the role each member plays in securing complete reporting of vital statistics.

A similar study can be made in any local health department without the use of punch cards. All that is required is current checking of maternity records, infant and preschool health records, and infant-death records with birth and stillbirth summary cards. Such checking will focus the attention of the health-department personnel on birth registration, with resulting improvement in registration.

Classification of Causes of Stillbirth

The Classification of Causes of Stillbirth, proposed by the Children's Bureau for use in the United States, was approved for publication and trial on October 7, 1940, by the Committee on Research and Standards of the American Public Health Association.

The classification includes: (1) A List of Causes of Stillbirth, (2) a Tabular List showing approved or frequently reported terms included under each title of the List of Causes of Stillbirth, and (3) Rules for Joint Causes of Stillbirth showing the relation between the list titles for selection of the preferred cause of stillbirth when two or more causes are reported on the same certificate.

The classification was prepared by Dr. Tandy of the Division of Statistical Research of the Children's Bureau with assistance on medical aspects from Dr. Daily, Director of the Maternal and Child Health Division, and Dr. Dunham, then Director of the Division of Research in Child Development. The United States Bureau of the Census gave advice on many technical matters. It has been given thorough study by clinicians and pathologists and has been approved by the members of the subcommittee on stillbirths of the American Public Health Association, the members of which are Haven Emerson, M. D., chairman, Fred L. Adair, M. D., D. Anthony D'Esopo, M. D., Ethel C. Dunham, M. D., and Elizabeth C. Tandy, Sc. D.

For the purpose of developing a classification of causes of stillbirth to serve as a basis for statistics that would fulfill the needs of clinicians, pathologists, and other workers engaged in maternal and child-health activities, the Children's Bureau in 1936, with the cooperation of the subcommittee on stillbirths of the American Public Health Association and the United States Bureau of the Census, initiated a study of stillbirths in hospitals.

The need for such a classification had been pointed out by the subcommittee on stillbirths in its report to the vital-statistics section of the association at the annual meeting of the association held in Milwaukee in October 1935. For this study hospitals in every section of the country agreed to have their physicians prepare and forward to the Children's Bureau a schedule for every stillbirth that occurred in connection with the hospital. The study is based on 6,750 stillbirth schedules supplied by 223 hospitals located in 49 cities in 26 States. The schedules of the study afforded the basic information used in formulating the classification. The study has demonstrated that the classification is practicable for use by statistical offices and will afford data needed for improvement of maternal and child health.

The List of Causes of Stillbirth is so designed that statistics compiled in accordance with it may be consolidated to afford data on stillbirths in the United States for purposes of comparison with those of countries that use the International List of Causes of Stillbirth adopted by the International Commission for the Revision of Causes of Death at its meeting in Paris in 1938. For use in the United States the International List had not been found entirely satisfactory. Many factors, including variation in evidence of life used in differentiating live births and stillbirths, variations in registration requirements with respect to period of uterogestation, and variations in procedures used by statistical offices for classifying cause of stillbirth in the different countries, will, unquestionably, limit the comparability of the statistics of one country with those of another. It is believed, however, that the adoption of this classification by the United States and its application on a wide scale by the United States Bureau of the Census will make available a body of data sufficiently reliable to permit the development at the meeting of the International Commission in 1948 of an international classification system for stillbirths that will meet with universal approval.

Copies of the classification may be obtained from the Children's Bureau.

BOOK NOTES

CONGENITAL SYPHILIS, by Charles C. Dennie, M. D., and Sidney F. Pakula, M. D. Lea & Febiger, Philadelphia, 1940. 596 pp. $8.

This book of nearly 600 pages is devoted to a description of congenital syphilis and a discussion of many of the problems closely related to syphilis of the second generation. The book is both a review of the literature and a digest of the authors' own observations and experience. The United States Public Health Service aided the authors by supplying abstracts of much of the current literature, both in English and in foreign languages.

In chapter 1 the examination of the congenitally syphilitic child is discussed. The symptoms of the acute disease in infancy as well as the stigmata of later childhood are outlined.

The title of the second chapter is "The Serological Reactions and their Significance." The relative values of the Kolmer Wassermann, the Kline precipitation, and the Hinton precipitation tests are compared in the authors' series of 500 cases of known congenital syphilis. In this chapter are discussed also the pathology, the allergic aspects, the immunological aspects of syphilis as well as the significance of seroresistance in syphilis.

Chapter 3 is devoted to a discussion of syphilis of pregnancy. A special section in this chapter written by Smith and Calkins is devoted to statistics of syphilis in obstetrics. In this chapter the effects of syphilis on both mother and child are described as well as the problems of diagnosis and treatment of syphilis in the pregnant woman.

The succeeding 11 chapters are devoted to detailed description and discussion of the clinical manifestations of congenital syphilis. In each chapter the lesions of early acute congenital syphilis are described first (if they exist) and then the lesions of the same body structure attributable to tardive syphilis.

Chapters 15 to 18 are each short and deal with diagnosis of congenital syphilis in its latent phases, congenital syphilis in the adult, syphilis in the third generation, and congenital syphilis in twins.

Chapter 19, the longest in the book (115 pages), deals with the treatment of the congenital syphilitic.

The book ends with a short chapter on the differential diagnosis between congenital and acquired syphilis in infants and children.

D. V. W.

GETTING READY TO BE A MOTHER, by Carolyn Conant Van Blarcom. Revised by Hazel Corbin. Macmillan Co., New York, 1940. 190 pp. $2.50.

The fourth edition of this book has been prepared by Hazel Corbin, general director of the Maternity Center Association, New York, and is a complete revision of the old text. The new book is shorter than the old one and somewhat more popular in style, and it contains more pictures without, however, sacrificing any of the accuracy of the original book.

In the first chapter the book is more or less summarized by giving the personal history of one woman and her baby in a series of 24 full-page pictures.

The succeeding chapters discuss in detail subjects introduced by means of the personal story. In chapter 2 the physiology of pregnancy is explained, using as illustrations pictures of models prepared by Dr. Robert L. Dickinson for the New York World's Fair exhibit of the Maternity Center Association. Chapter 3 contains information concerning prenatal care, giving in simple language not only the things to do and not to do but also the reasons why such conduct is desirable. Chapter 4 is devoted to the nutrition of mother and baby.

The next two chapters contain suggestions concerning the mother's needs during the confinement, whether it be at home or in the hospital, and the needs of the baby immediately after arrival. There are many practical suggestions about things that can be made at home. Labor, called the baby's birthday, is described in detail in chapter 7, and pictures of more of Dr. Dickinson's models are used as illustrations. The puerperium is likewise explained (chapter 8) with the aid of these models. From an understanding of the physiological changes taking place during labor, delivery, and the puerperium the necessity for the care required follows simply and logically. Breast feeding is discussed, and methods are given by which almost all mothers can successfully breast feed their babies (chapter 9).

The care of the baby in the first few weeks of life is described. Emphasis is placed upon regularity of feeding schedules, and early toilet training is recommended. The book devotes most of its pages to the essentials of getting ready to be a mother. It offers only a few suggestions on baby care and recommends further reading on the subject.

A chart (17 by 13 inches) for recording the baby's weight is placed in a pocket on the back cover of the book.

D. V. W.

The Children's Bureau *does not distribute* the publications to which reference is made in THE CHILD except those issued by the Bureau itself. Please write to the publisher or agency mentioned for all others.

Social-Service Functions in Children's and Family Courts[1]

By Alice Scott Nutt

Assistant Director, Child Guidance Division, U. S. Children's Bureau

Last year at the National Conference of Social Work I discussed The Future of the Juvenile Court as a Case-Work Agency, expressing the point of view that ultimately the treatment function, or case work, now undertaken by the juvenile or children's court following adjudication or disposition of a case should be transferred to administrative social agencies. Because of some misunderstanding regarding certain aspects of my earlier paper, a few points should be clarified before discussion of social-service functions in children's and family courts is entered upon. I did not then and do not now propose that the children's court should be abolished and all its functions transferred to another agency. Under our system of democratic government, a court to receive petitions in regard to conflicting claims and to render decision between them will be a social necessity as long as controversies arise between individuals, between organizations, and between individuals and organizations. My thesis was that certain functions properly belong to the court and other functions belong to administrative agencies. This belief is not based upon a concept of a mythical court which is a composite of all courts and, therefore, typical of none; nor is it based on the assumption that most courts are poorly staffed or ill-equipped, for undoubtedly the staff and facilities of the court in some communities can bear comparison with those of the best social agencies. Neither is my point of view based upon the treatment failures of some courts, except as these failures indicate that the court is attempting to perform incongruous functions. Even if all courts had well-qualified personnel, adequate facilities, and high standards of case work, the basic problem under consideration would remain. I believe that attempt should be made first to discover fundamental principles and, in the light of them, to determine the ultimate goal. Then along the lines of these principles and in the direction of that goal, existing services should be strengthened and new ones developed.

Children's and family courts carry many responsibilities. Children's courts deal with violations of law by children and with children whose behavior is likely to endanger the health or welfare of themselves or others. They intervene to protect children whose welfare or normal development is endangered, or who lack parental care. Because children's problems are frequently the result of unfortunate relationships with adults or of family situations, many children's courts have jurisdiction in certain cases involving adults. Family courts may have juvenile jurisdiction as well as jurisdiction over problems arising out of the family or marital relationship, such as nonsupport, desertion, and divorce. To meet the social problems involved in the cases over which they have jurisdiction and in which they must make and enforce orders, the courts have developed a variety of services. Among these are social investigations, case-work treatment of children and adults, administration of specialized services, and sponsorship of various community activities directed toward the prevention of juvenile delinquency.

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[1] Speech given before Law and Social Case Work Section of the New York State Conference on Social Work, New York, October 9, 1940.

Most agencies exercise a single major function or several functions of similar character. Review of the many and varied services which children's and family courts render shows that they exercise two major and dissimilar functions: a judicial function and a treatment function.

In the early days of the children's courts, when they were attempting a new and socialized approach to old problems, the combination of treatment with judicial functions came about naturally. The resources available in the community were meager or inadequate, and the courts therefore developed investigatory, clinic, and supervisory services as part of their own administration or in close relation to it. Early in the twentieth century protective measures for children were enacted, including the care of children in their own homes at public expense, the administration of which required social services. The courts had developed such services; therefore, they were called upon to administer these measures. When family courts were organized to deal with the family as a unit, the growth of their social services was according to a pattern similar to that of the children's courts established a few years earlier. Their sponsors sought to expand the services set up for dealing with the problems of individual children, to deal with those of the family.

To a considerable extent the original reasons for the court's assumption of treatment functions no longer exist. Since the establishment of the court new treatment services, both public and private, have come into being, including psychological and psychiatric care, attendance and visiting-teacher service, group work, special classes in schools, foster-home placement, and special institutions for children presenting behavior problems. Agencies have expanded and strengthened their services; for example, many family-service agencies have equipped themselves to give psychiatric case-work service in domestic problems. It is significant that public and private agencies now handle problems similar to many with which the courts deal. Sophia Moses Robison's study, "Can Delinquency Be Measured?" brought out very clearly that a considerable number of court cases represent minor problems, and that a considerable number of children referred to agencies other than the court are brought to the attention of the agencies for problems quite as serious as those with which the court is presumed to deal.[2] We know also that two courts operating under the same law may deal with widely varying proportions of the problems relating to children in their respective communities, because of differences in the concepts of the community and the court itself as to the function and place of the court in the whole child-welfare program.

Not only do these considerations raise questions as to the necessity of the court's continuing to function as a treatment agency, but other factors also raise questions as to the desirability of its doing so. By virtue of its status as a court, the community, the child or family, and its own staff hold certain concepts with regard to it; by virtue of its function as a judicial agency it has a structure and a procedure which differ markedly from those of a nonjudicial case-work agency. These concepts and its structure and procedure impose upon the court's use of case-work processes and techniques limitations that the nonjudicial agency does not experience.

In its thinking the general public closely associates the children's court and the family court with other courts, the criminal law, and punishment. This concept may cause the community to act in either of two ways. It may look to the court for protection from the individual and, therefore, may exert pressure upon the court to deal quickly and decisively with what it considers socially unacceptable behavior. Thus it looks upon the court as a law-enforcement agency rather than a treatment agency and so creates an atmosphere of authority in which it is difficult to adhere to the modern concept of modifying behavior by offering the individual an opportunity for the development of his own potentialities. The community may react in another way. It may hold that any contact with the court is prejudicial to the individual and therefore refrain from court action until the problem has become well-nigh insoluble.

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[2] Robison, Sophia M.: Can Delinquency Be Measured?, pp. 205–206. Published for the Welfare Council of New York City by Columbia University Press, New York, 1936.

The individual over whose case the court takes jurisdiction rarely comes to it voluntarily. This fact and the concept of the court which the individual holds as a member of the community make it difficult for the court to establish a therapeutic relationship with him. He is likely to be suspicious, resentful, and resistant to treatment. He may be weighed down with a sense of guilt and humiliation, or he may enjoy the court experience and have a sense of prestige and self-glorification as a result of it.

The court staff is not entirely free from concepts similar to those held by the community and the child. Furthermore, the powers given to the court are so broad as to constitute danger both to judge and to probation officers lest they themselves become victims of the atmosphere of authority. There is an ever-present temptation to try to achieve by authoritarian methods what the nonauthoritarian agency must achieve by case-work methods.

The case work of the court has to be done within the framework of the court organization. The procedure of the court, although socialized, nevertheless must follow certain legalistic lines. Every official case must go through certain processes—a petition is filed, an investigation made, a decision as to detention reached, witnesses summoned, a hearing held, and an order made. Furthermore, in the handling of individual cases the relation of the probation officer to the judge differs markedly from the relation of the case worker to the administrative head of a noncourt agency. The director of the noncourt agency is primarily an administrator who gives the major part of his time to the formulation of policies and programs and to administrative duties. He employs experts in the social-work field to whom he delegates responsibility for case work with individuals. The head of the court is the judge. In the exercise of his judicial function he is likely to have to give so much time to hearing individual cases that he has little time left for consideration of broad administrative policies. At times, because both deal directly with individuals, he and his staff may be in conflict on treatment procedures, a situation rendered more difficult by the fact that the staff is presumably expert in the case-work field whereas the professional training of the judge has generally been in the field of law; rarely has he had training in social work.

There are those who admit these handicaps to case work in the court but look upon them as challenges to the court to improve the quality of its personnel and to raise its standards of work. This is sound insofar as it relates to functions of which the court cannot divest itself. But is it necessary for the court to continue to perform, under handicap, functions which another agency can perform without this handicap? There are those who argue that authority has a place in treatment in children's cases. This is a point on which sound research is needed, for as yet little is known about what this place is and when authority should be used. For the present let us grant that there are times when authority must be used. But should it be used as the setting within which whole categories of cases are dealt with regardless of whether need for it exists in individual cases, or should it be used as a tool of treatment in specific cases and on the basis of recognition of the need for its use in those cases?

We need to recognize what Dr. Thomas Eliot, who has argued this question for many years, points out; namely, that essentially judicial functions are incongruous with functions of child care and treatment; that when incongruous functions are performed by a single agency, social efficiency is retarded and motivation and attitudes are clouded; and that functionally the case-work services and treatment processes of the court have more in common with similar services of noncourt agencies than they have with the judicial services of the court.[3] The mixture of functions may be responsible for criticism of the court as an entity when only one aspect of its work merits such criticism. The court as an agency may be blamed for the lack of success in a given case. The best case-work efforts of the probation staff may have been expended to no avail because an unwise disposition or order was made by the judge in the first place. In another case the failure may have been entirely in the treatment service, yet unfavorable reflection may be cast upon the judicial decision in which there was no error.

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[3] Eliot, Thomas D.: Case-Work Functions and Judicial Functions; their coordination. Yearbook of the National Probation Association, 1937, pp. 252-266.

Separation of judicial and treatment functions, however, with the court retaining responsibility for the judicial functions and administrative agencies, both public and private, assuming responsibility for treatment functions would relieve this anomalous situation, would further development of the potentialities of each, and would promote harmonious relationships.

Children's and family courts have worked out socialized procedures in judicial functions such as receiving complaints; detaining or summoning persons essential to the proceedings; obtaining clinical and social facts through impartial fact-finding personnel; conducting hearings; arriving at diagnostic and prognostic opinions; rendering decisions and making orders essential to carrying them out; and, when necessary, enforcing such orders. These socialized procedures could be extended to all court actions in children's and domestic-relations cases through the centralization of jurisdiction in these cases in a single court. I have in mind jurisdiction in cases of delinquent and neglected children, dependent children whose custody or guardianship is in question, minor offenders who are beyond the age of juvenile-court jurisdiction, and adults contributing to delinquency and dependency; and in cases of desertion and nonsupport, estabishment of paternity and support of children born out of wedlock, annulment of marriage, divorce, separate maintenance, adoption or guardianship, and the commitment of mentally defective children. Rarely is jurisdiction in these various types of cases vested in a single court. In most States it is divided among specialized courts (children's, family, or domestic-relations), criminal courts, and courts of probate and chancery jurisdiction.

The proposal to combine all children's and family cases in a single court would make it possible for the court to apply to them the socialized processes that have been developed. The proposal to separate judicial and treatment functions would permit it to operate as a socialized court without offering case-work services following adjudication. In this way a solution would be found to the dilemma that has faced those who wish to combine jurisdiction in all children's and domestic-relations cases but who hesitate to press the idea because it seems doubtful that the court, carrying such a load, could furnish adequate social services. With the jurisdiction of the court augmented and with its extraneous functions eliminated, those interested in it would no longer try to make it a hybrid agency—half-fish and half-fowl. Instead they would recognize value in the fact that in the thought of the community the court remains a court. They would emphasize the idea that the court exists as an impartial arbiter in controversies, as an instrument of social authority, and as a personification of justice.

For 40 years the children's courts have had a proprietary interest in cases of delinquent and neglected children. Under the doctrine of parens patriae they have built up a sense of responsibility for the actual care and treatment needed by these children. They have, therefore, been reluctant to relinquish responsibility for the administration of treatment services. But, as I mentioned earlier, since these courts were organized new agencies and specialized services have come into being and old agencies have strengthened or expanded their original services. Furthermore, many of the noncourt agencies now deal with cases in which the circumstances are similar to those in cases with which the courts deal. Along with these changes has gone analysis of the causal factors in the problems dealt with and revision of the concept of what constitutes adequate treatment. In the words of the General Report of the 1940 White House Conference on Children in a Democracy—"In a democracy responsibility for the care of children centers in the family. Social services furnish the means by which society helps to meet the special needs of children whose well-being cannot be fully assured by their families and by those community services that are intended for all children alike.

The primary objective of child-welfare service is to provide for every child who has some special need whatever assistance and guidance may be required to assure him security and protection, within his own home if possible, and opportunity for his growth and development."[4]

Neglect, delinquency, domestic discord, and other maladjustments of child and family life are no longer looked upon as isolated conditions. We are increasingly aware of the kinship among them: of their roots in the disorganization, inadequacies, and insecurities of family life, as well as in the still broader problems of economic and social life; and of their nurture by deficiencies in community provisions for health, educational, recreational, social, and other services. Recognition of the nature of the problems brings with it the realization that if they are to be dealt with adequately social planning must take into consideration the needs of all children and of all families. Services for family and child welfare must include material assistance to families, health services, provision for those handicapped mentally or physically, social services, and various special services.

To be most effective treatment services must be brought into close relationship with one another and with community agencies for child and family welfare. They must also be made available and utilized for the child in danger of becoming delinquent and for the family in danger of being broken long before the stage is reached where it is necessary for the court to intervene.

Interrelationship and integration of treatment services can be more readily effected among agencies with similar structure and functions—for example, the administrative social agencies of the community—than between court and noncourt agencies. I do not mean to imply that all prevention and treatment services should be combined in a single "over-all" agency, although trends in the public-welfare field indicate that generalized as well as specialized services can function in a single department to an extent that was hardly thought possible in the past.

Case work with children and families carried on outside of the court is freed from the limitations placed upon it by the authoritarian atmosphere of which it is well-nigh impossible to divest the court, despite the best intentions of judge and probation staff. Furthermore, when specialized service can be sought and obtained without the necessity of court referral, parents, individuals, schools, and even police officers are more likely to seek aid in children's problems at the earlier stages in which prognosis is more hopeful. In this connection it is significant that attention is now being paid to the possibility of preventing delinquency by making help in behavior problems available through what are accepted by the community, parents, and children as natural channels and natural points of contact, such as the school, the child-health center, the recreation or group-work agency, and the children's or family agency already in touch with the family because it is rendering another service.

In general, the transferral of treatment functions from the court to administrative agencies will have to come about gradually and as an evolutionary process. Not in every community at the present time can children who come to the attention of the court or police, but in whose cases no judicial decision is needed, be routed directly to social agencies. The very fact that some courts have thought it necessary to develop unofficial work and that their doing this has been accepted by the community is an admission that there are cases which do not belong in the court category but for which no other agency has assumed adequate responsibility. Not in every community can children be taken to court for judicial action in their cases and then transferred to social agencies for treatment. In other words, treatment facilities in administrative agencies may be and often are inadequate or lacking. Many areas are still without adequate social services for children and families. Service to children in their own homes is often less readily available than care away from their homes. Frequently there is an oversupply of facilities for care of one type of problem—for example, institutional or foster-family care for dependent and neglected children—and at the same time lack of provision for specialized care needed by children with physical, mental, or emotional handicaps or difficulties.

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[4] Children in a Democracy—General Report Adopted by the White House Conference on Children in a Democracy, January 19, 1940, Washington, D. C., p. 63. Children's Bureau, Washington, 1940.

If, however, it is agreed that treatment functions belong to administrative agencies rather than to the court, the community must accept responsibility for planning how best to equip these agencies to discharge their responsibility. In many communities, if not most, it will be necessary to develop specialized social services to meet the needs in the problems presented. Growth of social services will have to be along the lines recommended by the White House Conference of 1940, which take into account both the basic needs of all families and children and the special needs of those who suffer from disabilities and maladjustments—a type of work which is now being developed in some places and which is the goal of child-welfare work in many States.

Some courts are themselves taking responsibility for clarification of functions and responsibilities. They are discouraging the filing of petitions for trivial incidents; they are recognizing that cases of dependency and neglect need not be brought into court unless problems of custody or willful neglect are involved, and they are referring, at the point of application, cases in which the need can be met by the service of an agency other than the court. In connection with this comment on the type of intake work that some courts are doing, I should like to affirm my belief that the court will continue to need persons trained in case work and to use case-work skills even though ultimately it does not carry on case-work treatment following disposition of cases. Highly selective intake service, social investigations that are diagnostic in character and quality, and the selection of treatment services for referral, all require understanding of causal factors, appraisal of situations, and recognition of the potentialities of treatment. In addition, the processes of intake and investigation will afford many opportunities for bringing about social adjustments through short-time contacts—which, by the way, should not be confused with the unofficial handling of cases—that require the use of case-work techniques.

Although the transferral of treatment services in court cases to administrative agencies will come about slowly in some communities, rapid development is possible in others.

A significant development is taking place, in rural areas especially, which is rapidly changing the old pattern or creating a new one. The last two decades have witnessed the rapid expansion of local public-welfare agencies equipped to give services to children and families. For a number of years several States have had provision for such units in which it has been possible to bring together various kinds of specialized services and to employ well-qualified persons to administer them. Services of these units have been expanded and strengthened by the provisions of the Social Security Act which authorize the expenditure of public funds to assist the States and Territories (1) in providing public assistance for various groups of dependent persons, including dependent children living in the homes of parents or relatives when they are deprived of the support or care of a parent by death, desertion, or physical or mental incapacity, and (2) in employing child-welfare workers in areas predominantly rural. As a result of these two provisions, local public-welfare departments with broad responsibilities for persons in need have been established throughout the country.

These departments have been given definite responsibilities for services to children including case work with children in danger of becoming delinquent and the performance of administrative functions relating to the care and support by local officials of delinquent, dependent, and neglected children. Legislation of recent years has recognized that cases of dependency and neglect need not be brought into court unless problems of custody or willful neglect are involved and has empowered public child-caring departments to accept for care without court action children about whose custody there is no controversy and whose primary need is for case-work services and support from public funds. Social interpretation and administration of these measures, made possible by the general phraseology in which their responsibility to neglected children is expressed, will permit the departments to perform protective services—investigate complaints, do rehabilitative work with families, or plan for the care of the children—services which hitherto the court has performed because of the lack of other public agencies. In many States these departments are specifically authorized to assist the children's court, and in some counties all case-work services for children coming to the attention of the court are performed by the children's worker attached to the local public-welfare department.

From this it appears quite likely that the judicial and treatment functions of children's and family courts will ultimately be separated. Progress throughout the country will be uneven. While rather rapid developments are taking place in areas predominantly rural and areas hitherto unorganized, developments move more slowly in urban areas and areas in which there is a multiplicity and complexity of social organization. Urban areas have proceeded much more slowly than rural areas in setting up public child-welfare departments with broad, integrated services. Nevertheless, several large urban communities have organized such departments or are taking steps in that direction. Eventually such departments will make available to the court facilities for the exercise of administrative social-work functions in relation to the exercise of judicial functions, and as they do so they will inevitably mold and modify the structure of the children's and family courts.

With this division and revision of the functions of the socialized court and the social agencies, close working relationships and mutual confidence will be needed. The services of the agencies must be readily accessible to the court and the services of the court readily accessible to the agencies. In the solution of many social problems each will play an essential part. For example, the court by judicial order may make possible a change of environment that is necessary if the agency is to carry on effective treatment of the child. The agency will be strengthened in its handling of the occasional case in which authority is an essential component of treatment when it is clear that the court stands behind it. The interest of the client will be safeguarded because the court offers an avenue of appeal not only to the agency but to the client also. The court and the social agency are units in a total program. Each must pursue vigorously its primary function and make the contribution that only it can make. Progress depends upon their united efforts, combined strengths, and, above all, mutual respect.

BOOK NOTES

Family Welfare Association of America

Among publications recently received from the Family Welfare Association of America (122 East Twenty-second St., New York) are the following that deal with the theory and techniques of family case work:

Evaluations of Staff Members in Private Family Agencies, analyzed by Margaret Kauffman and Helen Malmud (1940. 37 pp. 40 cents). This pamphlet is pertinent and timely for workers not only in private agencies but also in public-welfare departments where merit systems require periodic evaluation of the workers' services. The general discussion of the theory of evaluation includes controversial points such as whether the evaluation should be read by the worker. Sample forms submitted by a number of agencies are given for classifying workers. Various procedures followed in evaluating workers are discussed.

Three Studies of Family Case Work Programs (1940. 59 pp. 65 cents). These studies are "self-evaluations" made by staff and board members of the family-welfare agencies in Scranton, Pa., Ann Arbor, Mich., and Springfield, Mass. In the foreword it is stated that changes in scope and type of responsibility of private family agencies have given rise to many questions in the last few years. The three studies attempt to some extent to answer these questions and to give information on the method of the study and data in regard to agency function and practice.

Cultural Problems in Social Case Work (1940. 58 pp. 50 cents). The three papers contained in this pamphlet present the influence on the client of cultural heritage and the significance of this background to the case worker. The papers are: Cultural and Racial Problems in Social Case Work With Special Reference to Work With Negroes, by Maurine Boie La Barre; Cultural and Psychological Implications in Case Work Treatment With Irish Clients, by Elise de la Fontaine; and Some Cultural Aspects of Social Case Work in Hawaii, by Eileen Blackey.

A Guidebook for Beginners in Public Assistance Work (1940. 49 pp. 40 cents). This pamphlet was written by a case consultant of the State Bureau of Social Security at the request of the case-work supervisors in a large county in Michigan to meet the need for material to orient new workers.

Short Contacts by the Home Economist in Case Work Treatment (1940. 20 pp. Mimeographed. 20 cents). Two papers which were given at the National Conference of Social Work in 1939 make up this pamphlet. The first paper, by Luise Addiss, is written from the point of view of the home economist and discusses what can be accomplished when the home economist has only one interview, usually with the mother. The second paper, by Monica Jordan, presents the point of view of the case worker.

THE FEDERAL JUVENILE DELINQUENCY ACT AFTER TWO YEARS OF OPERATION, by Arthur W. James, *Federal Probation*, Vol. 4, No. 3 (August–October 1940), pp. 21–25.

In this article the supervisor of the Juvenile Offenders Section of the Bureau of Prisons, United States Department of Justice, reviews the experience of the Department of Justice in administering the Federal Juvenile Delinquency Act during the 2 years that it has been operative, outlines the procedures developed to carry out the intent of the act to give a more socialized type of treatment to young persons who violate Federal laws, and enumerates some of the problems of jurisdiction and resources encountered.

LOVE AT THE THRESHOLD, by Frances Bruce Strain. D. Appleton-Century Co., New York, 1939. 349 pp. $2.25.

Hundreds of young people have contributed much in form and content to this book through their questions and discussions, the author says. It is offered as a counselor and guide to young people, whether graduating from high school, attending college, or working at a job, who are dealing with the realities that young men and women face.

> Though love and its accompaniments are immortal and the quest for them unending and universal, each generation forges a new pattern of conduct and builds a new pathway toward this old land of heart's desire. The crossing of the new ways and the old, the difference between your ways and mother's and father's, grandmother's and grandfather's ways, the breaking in of the new pattern upon the old pattern of social custom, create in every young person a tangle of conflicting ideas. What, exactly, is right? What is right socially, ethically, healthfully? How does one know?

Divided into three parts, Dating, Romance, and Marriage, the book is rich in illustrative stories which "are not so much records of actual happenings as they are incidents suggested by a variety of experience which can happen to anyone, anywhere, any time."

AS THE TWIG IS BENT, by Leslie B. Hohman, M. D. Macmillan Co., New York, 1940. 291 pp. $2.50.

The title of this book describes fairly well its author's point of view on the importance of early habit training in children. He describes, with much illustrative material, the effect of training in infancy and childhood on adult attitudes and behavior, emphasizing the point that the young child is a plastic thing easily molded into the pattern set by his environment. Dr. Hohman minimizes, although he does not ignore, the role of heredity or constitutional inadequacies in the ultimate development of personality maladjustments. He believes that strict training and insistence on conformity to the standards of the home are essential to later happiness. He is opposed to the doctrine of what he calls "no repression" and believes that the child brought up with a minimum of control and discipline will be unfitted to cope with society when he graduates from the fireside.

SOCIAL CASE WORK WITH CHILDREN; studies in structure and process, edited by Jessie Taft. *Journal of Social Work Process*, Vol. 3, No. 1 (December 1939). Pennsylvania School of Social Work, 1940. 237 pp.

The editor comments in the introduction on the lack of literature in the field of child care in contrast to the wealth of material coming from the psychiatric and family-welfare fields. She states also that the studies in this volume are devoted to a clearer formulation and exposition of what is implied in the placement of the dependent child in a foster home and the relation of this form of care to the community. All the papers have a central theme; that is, the kind and degree of responsibility to be assumed professionally and the relation of that responsibility to the growth process going on in the child himself, to the adults on whom he depends, and to the community that supports him.

• CHILD LABOR •

• YOUTH EMPLOYMENT •

• VOCATIONAL OPPORTUNITIES •

Child-Labor Legislation in 1940

By Lucy Manning

Industrial Division, U. S. Children's Bureau

Considerable interest in child-labor standards was displayed during 1940 in the legislatures of the eight States meeting in regular session, legislation affecting minors being introduced in each of these States. Only a few bills, however, were enacted into law. The most important advances were made in New Jersey, where companion child-labor and compulsory-school-attendance laws were enacted, culminating years of efforts on the part of organizations and persons interested in child welfare to improve child-labor standards. In addition, a few advances occurred in other States, either in basic standards or in improvement or simplification of administrative provisions. On the other hand, a few laws were enacted which result in relaxing standards or in expressly narrowing the application of laws that affect working minors.

The New Jersey child-labor act was completely revised and comprehensive child-labor provisions were adopted,[1] which not only meet the standards of the Fair Labor Standards Act of 1938 but bring this State well to the forefront in progressive child-labor standards. This act is significant in that it includes within its coverage employment in agriculture, thus dealing with one of the major child-labor problems in New Jersey arising from the work of children in industrialized agriculture within that State. Farm work and domestic service performed outside school hours for the child's own parent and in connection with his own home are entirely exempt from the new law. For agricultural work not for the child's parent and not on his home farm the law sets a minimum age of 16 during school hours and 12 during vacation and outside school hours; special permits are required for employment of children between 12 and 16; daily hours for children under 16 are limited to 10 except on school days, when combined hours of work and school may not exceed 8 a day.

The New Jersey Legislature took special cognizance of the problem resulting from the influx into New Jersey for work in industrialized agriculture of children from neighboring States, particularly Pennsylvania. Many of these children leave school before the school term closes, go into New Jersey for farm work, and often do not return home until after school opens, with the result that their school progress is seriously retarded. The new act prohibits nonresident children from working in New Jersey at any time during which the law of their State of residence requires their attendance at school, as well as at any time during the hours when schools are in session in the district where they are employed. This provision is particularly significant in that it recognizes a responsibility of one State for the children of another. It complements even more comprehensive legislation enacted by Pennsylvania in 1931, following numerous conferences between officials in New Jersey and Pennsylvania and other nearby States to consider the problem of protecting the migratory child from the effects of child labor.

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[1] N. J., Laws of 1940, ch. 153.

High standards are set by the act for employment in industrial and commercial work. A basic minimum age of 16 years is established for employment, New Jersey becoming the thirteenth State to adopt this standard. Employment of children under 16 years of age is prohibited in factories at any time and also in any occupation during school hours. For work outside school hours there is a minimum age of 14 in all nonfactory and nonprohibited work, except in street trades, for which special regulations apply. Employment certificates are required for minors up to 18 years of age, instead of 16 as formerly. Certificates to prove age may be obtained by or for young persons between 18 and 21 years of age. Hours-of-labor and night-work standards are improved, New Jersey becoming the second State to adopt a maximum 40-hour week for minors under 18. Night work is prohibited for 13 night hours for minors under 16 and, with certain exceptions, for 8 night hours for minors between 16 and 18 years of age.

For work in street trades outside school hours there is a minimum age of 14 years for boys (12 years for boys working as newspaper and magazine carriers on residential routes) and 18 for girls; special permits are required and night work is prohibited for boys up to 16 years of age.

The law also provides for minors greater protection than formerly from work at hazardous occupations. Children under 16 are prohibited from work in connection with power-driven machinery; a minimum age of 18 is established for specified hazardous employment, instead of 16 as formerly; and employment of minors under 18 in such other occupations as may be declared hazardous by the State Commissioner of Labor, after public hearing, is also prohibited.

New Jersey also amended its compulsory-school-attendance provisions,[2] adjusting them to dovetail with the new child-labor standards. Attendance is required up to 16 years unless the child is physically or mentally incapacitated. With the approval of the State Commissioner of Education and the State Commissioner of Labor, school attendance of children between 14 and 16 under certain conditions may be combined with a part-time work program carried on as part of their schooling.

Virginia likewise strengthened its school law, although a proposal to raise the upper age for compulsory attendance from 15 to 16 years failed, and the power formerly vested in local boards of education to make the ages at which school attendance is compulsory 8 to 16 instead of 7 to 15 years of age was removed.[3] The minimum school term was increased from 160 to 180 days.[4] Compulsory-school-attendance provisions were somewhat widened in their application to rural children through an amendment which brought within the coverage of the law children living at a greater distance from school than were required to attend under the former law. Administrative provisions for enforcing compulsory school attendance were strengthened, responsibility being placed on the State Board of Education to see that the compulsory-school-attendance law is properly enforced in the counties and cities of the State.[3] Boards of education were empowered to establish vacation schools and summer camps.[5] Virginia, in revising and codifying its mining laws, also incorporated a prohibition against the employment of minors under 18 as well as employment of women in or around any mine or quarry.[6] A minimum age of 18 had already been set for work in mines through an amendment to the child-labor law in 1936, but the new mining code establishes for the first time a minimum age of 18 for work in or around quarries. It also provides that operators in case of doubt should obtain a birth certificate or other documentary evidence as to the age of the person concerned.

In New York several laws affecting the employment and school attendance of minors were passed. The law relating to vacation permits was amended to delete the provision that such permits shall expire on the opening of school.[7] The apparent purpose of this amendment was to ease the administrative burden of reissuing certificates for children who legally may continue to work outside school hours in certain occupations even after school opens. The education law was amended to permit absences from school for religious observances and education, under rules of the State Commissioner of Education,[8] with the purpose of establishing uniform practices throughout the State in this regard. Continuation-school attendance of employed minors and minors not in full-time school attendance was also affected. Continuation schools are now required to be established in cities or school districts where there are at least 1,000 such minors, instead of 200 as formerly, and attendance is compulsory at such schools only in cities of 400,000 or more and in school districts having 1,000 or more employed minors under 17.[9] New York also relaxed its 6-day week and night-work prohibition so that girls over 16 years of age and women might work in floral shops on the day before Easter, Easter morning, and December 23.[10]

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[2] Ibid., ch. 154.

[3] Va., Laws of 1940, ch. 377.

[4] Ibid., ch. 182.

[5] Ibid., ch. 86.

[6] Ibid., ch. 150.

[7] N. Y., Laws of 1940, ch. 45.

Two States, New Jersey and New York, strengthened their laws regulating industrial home work. New York adopted two amendments, one requiring labels to be attached by the employer to all materials delivered for home work, showing his name and address in English;[11] the other, a clarifying amendment withdrawing the State Industrial Commissioner's power to suspend or revoke licenses of owners of places where home work is done,[12] the responsibility of owners to obtain such licenses having been removed in 1935. The New Jersey law provides that all home workers and employers in the hand-knitting industry shall keep a daily record for a 2-year period of all work done by such home workers.[13] It also requires employers to pay home workers immediately upon delivery of the completed work.

Legislation specifically relating to workmen's compensation for minors was adopted in only one State, New Jersey.[14] This State expressly relieved summer camps operated by organizations organized solely for religious or charitable purposes, such as the Boy Scouts of America, the Y. M. C. A., or the Knights of Columbus, from payment of double compensation in the case of minors under 16 injured while illegally employed.

Two States enacted laws affecting the administration of labor laws. Louisiana reorganized all the State executive departments, including the Department of Labor.[15] Provision was expressly made for a division of women and children in industry within that department, and the name of the head of the Department of Labor was changed from Commissioner of Labor to Director of Labor. In Kentucky the functions and duties of the Department of Industrial Relations were extended and restated;[16] as provided in 1936, this department was given exclusive jurisdiction of the administration of the child-labor law.

One State, Kentucky, set up a program of voluntary apprenticeship under approved State agreements, provided for the appointment of an apprenticeship council and administration of the program by the Department of Industrial Relations in cooperation with such council.[16]

Two States, Kentucky[16] and Rhode Island,[17] adopted acts permitting State cooperation in the administration of the Fair Labor Standards Act of 1938. Seven other States and Hawaii had enacted such legislation previously.

Certain areas of employment in which minors often engage were specifically removed from the coverage of unemployment compensation in two States and the District of Columbia. The District of Columbia[18] and Louisiana[19] both exempted services performed by persons under 18 in the delivery or distribution of newspapers or shopping news (except delivery or distribution to a point for subsequent delivery or distribution) from such coverage. In New York golf caddies were entirely exempted from the application of the unemployment-insurance law;[20] formerly only caddies employed by individual members of golf clubs or associations or their guests were exempted.

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[8] Ibid., ch. 305.

[9] Ibid., chs. 739 and 740.

[10] Ibid., ch. 216.

[11] Ibid., ch. 422.

[12] Ibid., ch. 386.

[13] N. J., Laws of 1940, ch. 98.

[14] Ibid., ch. 176.

[15] La., Laws of 1940, Act No. 47.

[16] Ky., Laws of 1940, ch. 105.

[17] R. I., Laws of 1940, ch. 895.

[18] 76th Cong., 3d Sess., Public No. 719, ch. 521.

[19] La., Laws of 1940, Act No. 11.

New York adopted a measure directed at protecting agricultural and other workers who are being transported in trucks.[21] Operators of trucks carrying 20 or more persons for distances in excess of 10 miles must comply with certain safety requirements. The need for legislation of this type was emphasized by the truck accident at McAllen, Tex., in March of 1940, in which, of a total of 44 persons, 29 persons, including 11 children under 16 years, were killed. Agricultural workers are often transported to farms from cities in crowded trucks under conditions detrimental to their safety and under circumstances so closely related to their employment that they may be considered job hazards.

In the field of Federal legislation no changes were made during 1940 in the child-labor provisions of the Fair Labor Standards Act. One act, the so-called Ellender amendment,[22] was passed, which affected benefit payments under the Sugar Act of 1937. This act includes as one of the conditions which producers of sugar beets or sugarcane must meet to obtain benefit payments, compliance with certain child-labor standards; i. e., that a producer may not employ or permit a minor under 14 years of age to work or a child between 14 and 16 years of age to work longer than 8 hours a day. The amendment provides that benefit payments may be made notwithstanding violation of the child-labor provisions, provided a deduction is made of $10 for each child for each day or portion of a day during which such child was employed illegally during the crop seasons of 1937, 1938, and 1939.

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[20] N. Y., Laws of 1940, ch. 217.

[21] Ibid., ch. 334.

[22] 76th Cong., 3d Sess., Public No. 660, ch. 423.

• EVENTS OF CURRENT INTEREST •

Two Grace Abbott Fellowships in Public-Welfare Administration

The editorial board of the *Social Service Review* is glad to announce two Grace Abbott fellowships in public-welfare administration.

1. A fellowship of $1,000 has been established by Delta Gamma fraternity in honor of the public services of Grace Abbott, who was a member of Kappa chapter of Delta Gamma when she was a student at the University of Nebraska. The fellowship has recently been announced by the national board of Delta Gamma and is established in honor of the public services of Grace Abbott as Chief of the United States Children's Bureau, as a member of the International Committee on Child Welfare of the League of Nations, and through her membership on other public-welfare commissions and administrative organizations. The Delta Gamma national board announces that the Grace Abbott fellowship will be awarded for the academic year 1941–42 to a woman graduate of an American college or university who has had experience in the public social services and who submits an approved plan for a year of professional study with the object of returning to the public-welfare service.

This Grace Abbott Fellowship in Public Welfare will be awarded by a committee of alumnae members of the fraternity, including Mrs. Arthur H. Vandenberg, Mrs. Joy Webster Bowerman, and Mrs. Ruth Bryan Rohde of Washington (D. C.), Blanche Garten of Lincoln (Nebr.), and Edith Abbott of Chicago, in cooperation with the chairman of the Delta Gamma student loan fund and also in cooperation with the fellowship committee of the American Association of

University Women. Application blanks may be secured after December 1 from the national secretary, Mrs. Russell Wildasin, 3019 Harvard Boulevard, Dayton, Ohio.

2. A Grace Abbott fellowship in the School of Social Service Administration is the result of the Grace Abbott Memorial Fund, which was begun last year at a meeting of her old students and associates at the Buffalo meeting of the National Conference of Social Work. This fund, which has not yet been completed, has been given to the University of Chicago for the permanent endowment of a Grace Abbott fellowship, and it is hoped that the income may be sufficient for a grant for the winter and spring quarters of the current academic year 1940–41. Like the Delta Gamma fellowship, this University of Chicago fellowship will be granted only to a candidate who has come from the public-welfare services and who plans to return to the public-welfare services. Because of the generous support given by Grace Abbott's old associates in the United States Children's Bureau, special preference will be given to candidates from the child-welfare services. The Chicago fellowship will be open to men as well as to women but will be available only for use at the School of Social Service Administration.

Grace Abbott cared so much about encouraging young men and women to give adequate time for preparation for the public social services that these fellowships seem a very appropriate way of honoring her own public service.

From Social Service Review, Vol. 14, No. 3 (September 1940).

Children's Bureau Publications

Publications issued during 1940 by the Children's Bureau include the following items. While the supply lasts, single copies can be obtained free on request from the Children's Bureau, United States Department of Labor, Washington, D. C.

White House Conference

Children in a Democracy—General Report Adopted by the White House Conference on Children in a Democracy, January 19, 1940, Washington, D. C. 86 pp.

Preliminary Statements Submitted to the White House Conference on Children in a Democracy, January 18–20, 1940, Washington, D. C. 257 pp. Contents: The economic resources of families and communities; Economic aid to families; Housing the family; Religion and children in a democracy; Education through the school; Leisure-time services for children; Library service for children and youth; Child labor and youth employment; Health and medical care for children; Social services for children; Children in minority groups.

Proceedings of the White House Conference on Children in a Democracy, Washington, D. C., January 18–20, 1940. Bureau Publication No. 266. 85 pp. This includes the General Report adopted by the Conference.

Social-Security Program for Children

Grants to States for Maternal and Child Welfare Under the Social Security Act of 1935 and the Social Security Act Amendments of 1939. Bureau Publication No. 253. (In press.) This is a revision of Maternal and Child-Welfare Bulletin No. 1.

Child-Welfare Services Under the Social Security Act, Development of Program, 1936–38. Bureau Publication No. 257. (In press.)

Child Guidance and Social Services

Children in the Courts, 1937; juvenile-court statistics, year ended December 31, 1937, and Federal juvenile offenders, year ended June 30, 1937. Tenth report. Bureau Publication No. 250. Washington, 1940. 88 pp.

Directory of State, County, and Municipal Training Schools Caring for Delinquent Children in the United States. Bureau Publication No. 264. Washington, 1940. 25 pp.

Child-Welfare Legislation, 1940. Mimeographed.

The Meaning of State Supervision in the Social Protection of Children, by Kathryn H. Welch. Bureau Publication No. 252, Washington, 1940. 22 pp.

Community Social Services for Children. U. S. Children's Bureau Folder 7 (Revised). 1939. 11 pp.

STATISTICAL MEASUREMENT IN GROUP WORK; a manual on statistical records for use by staff members, by Frances Adkins Hall. Bureau Publication No. 248, Washington, 1939. 103 pp.

Child Labor, Youth Employment, Vocational Opportunities

WELFARE OF FAMILIES OF SUGAR-BEET LABORERS; a study of child labor and its relation to family work, income, and living conditions in 1935, by Elizabeth S. Johnson. Bureau Publication No. 247, Washington, 1939. 100 pp. (Reviewed in *The Child*, May–June 1940.)

TREND OF CHILD LABOR 1937 TO 1939. Reprinted from *Monthly Labor Review*, January 1940, with supplementary material. 17 pp.

JUNIOR PLACEMENT; a survey of junior-placement offices in public employment centers and in public-school systems of the United States, by Jane H. Palmer. Bureau Publication No. 256, Washington 1940. 134 pp. (To be reviewed.)

YOUNG WORKERS AND THEIR JOBS IN 1936; a survey in six States, by Helen Wood. Bureau Publication No. 249. 95 pp. (To be reviewed.)

Child Health

METHODS OF ASSESSING THE PHYSICAL FITNESS OF CHILDREN, by Rachel M. Jenss, Sc. D., and Susan P. Souther, M. D. Bureau Publication No. 263. 121 pp. (To be reviewed.)

FACTS ABOUT CHILD HEALTH. March 1940. 11 pp. Processed.

FACTS ABOUT CRIPPLED CHILDREN. March 1940. 15 pp. Processed.

THE HEALTH SITUATION OF NEGRO MOTHERS AND BABIES IN THE UNITED STATES; a brief statement of health status, health services, and needs, by Elizabeth C. Tandy, Sc. D. 9 pp. Processed.

THE CHILD-HEALTH CONFERENCE; suggestions for organization and procedure. 57 pp. Mimeographed.

Nutrition Leaflets

WELL-NOURISHED CHILDREN. (In cooperation with Bureau of Home Economics, U. S. Department of Agriculture.) Folder 14.

THE HEALTHY, WELL-NOURISHED BABY; birth to 1 year. Folder 16.

THE HEALTHY, WELL-NOURISHED CHILD; 1 to 6 years. Folder 17.

THE HEALTHY, WELL-NOURISHED CHILD; 6 to 16 years. Folder 18.

FEEDING YOUR BABY; first year. Folder 20.

YOUR YOUNG CHILD'S HEALTH; 1 to 6 years. Folder 21.

YOUR SCHOOL CHILD'S HEALTH: 6 to 16 years. Folder 22.

THE NOON MEAL AT SCHOOL. Folder 23.

U. S. GOVERNMENT PRINTING OFFICE: 1940

CONFERENCE CALENDAR

1940

Dec. 26–28 American Statistical Association. One-hundred and second annual meeting, Chicago. Secretary: Frederick F. Stephan, 1626 K Street NW., Washington, D. C.

Dec. 27–29 American Sociological Society and affiliated organizations. Annual meeting, Chicago.

Dec. 27–30 American Economic Association and Southern Economic Association. Annual meeting, New Orleans, La.

Dec. 27–30 American Library Association. Midwinter conference, Chicago. Permanent headquarters: 520 North Michigan Avenue, Chicago.

Dec. 27–30 American Association for Labor Legislation. Thirty-fourth annual meeting, Chicago. Permanent headquarters: 131 East Twenty-third Street, New York.

1941

Jan. 25–27 Child Labor Day. Information and materials may be obtained from the National Child Labor Committee, 419 Fourth Avenue, New York.

Feb. 5 National Social Hygiene Day. Sponsored by the American Social Hygiene Association, 1790 Broadway, New York.

Feb. 9–16 Negro History Week. Sixteenth annual celebration. Information and materials are available from the Association for the Study of Negro Life and History, 1538 Ninth Street NW., Washington, D. C.

Feb. 13–15 American Camping Association. Eighteenth annual convention. Wardman Park Hotel, Washington, D. C. Permanent headquarters: 330 South State Street, Ann Arbor, Mich.

Feb. 19–22 Council of Guidance and Personnel Associations. Atlantic City, N. J.

Feb. 19–22 National Vocational Guidance Association. Annual convention. Atlantic City, N. J.

Feb. 20–21 International Council for Exceptional Children. New York. President: Dorothy E. Norris, State Board of Education, Cleveland, Ohio.

Feb. 20–22 American Orthopsychiatric Association. Eighteenth annual meeting, New York. Permanent headquarters: 1790 Broadway, New York.

Feb. 22–27 American Association of School Administrators. Atlantic City, N. J. Permanent headquarters: 1201 Sixteenth Street NW., Washington, D. C. Also, National Council of Childhood Education and other allied organizations.

UNITED STATES DEPARTMENT OF LABOR

Frances Perkins, Secretary

CHILDREN'S BUREAU

Katharine F. Lenroot, Chief

The Child is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives The Child.

The Child is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to the editor, The Child, Children's Bureau, United States Department of Labor, Washington, D. C.

The Child is for sale by the Superintendent of Documents, Washington, D. C., at $1 a year; foreign postage, $0.50 additional. Single copies are 10 cents each. Subscription orders should be addressed to the Superintendent of Documents, Government Printing Office, Washington, D. C.

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Social Statistics

Supplement Number 2, December 1940

to

THE CHILD—Volume 5, Number 6

Published by the
CHILDREN'S BUREAU
U. S. DEPARTMENT OF LABOR
WASHINGTON, D. C.

MAR 4 1941

The SOCIAL-STATISTICS SUPPLEMENT is issued by the Children's Bureau four times a year, in connection with the Bureau's monthly publication, THE CHILD.

The purpose of the supplement is to make available for general use summaries of current social statistics related to child welfare, prepared by the Bureau's Division of Statistical Research. While material presented in the supplement will be based largely on reports forwarded by health and social agencies in connection with the Bureau's project for the registration of social statistics, closely related material from other sources will also appear from time to time.

SOCIAL-STATISTICS SUPPLEMENT

Number 2 December 1940

TO

THE CHILD, Monthly Bulletin, Volume 5, Number 6

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UNITED STATES DEPARTMENT OF LABOR
FRANCES PERKINS
SECRETARY

CHILDREN'S BUREAU
KATHARINE F. LENROOT, Chief

REPORTING OF CASE-WORK SERVICES TO CHILDREN UNDER THE SOCIAL SECURITY ACT, TITLE V, PART 3

During the first years of administration of Federal funds for child-welfare services under title V, part 3, of the Social Security Act, no formal statistical reports were required by the Children's Bureau, as it seemed desirable first to see the ways in which "child-welfare services" would be developed in local units in the various States. For a period of almost 2 years the Child Welfare Division of the Children's Bureau, the division administering Federal funds for child-welfare services, participated with State public-welfare agencies in the experimental study of ways to obtain information in regard to that part of the program that related to direct case-work services for children. This exploration laid the foundation of a reporting plan for child-welfare services which was initiated in January 1940 by the Division of Statistical Research of the Children's Bureau in cooperation with the Child Welfare Division. In the development of this plan it has been the hope of the Children's Bureau that the data obtained might provide a means of interpreting child-welfare problems in the local communities and might be of assistance to the State public-welfare agencies in helping local communities to establish adequate services throughout the State.

By June 1940, 48 States, the District of Columbia, Alaska, Hawaii, and Puerto Rico were cooperating with the Children's Bureau in the administration of child-welfare services. The Social Security Act as amended in 1939, authorizing an annual appropriation of $1,510,000 for child-welfare services, provides for allotment of $10,000 to each State and the allotment of the remainder on the basis of the ratio of the rural population in the State to the total rural population in the United States. In the development of State plans differing conditions in the States are taken into consideration in order that the funds available may be used, within the limitation of the law, for purposes that will contribute most to the development of the child-welfare program in each State. Although every State plan for child-welfare services provides for the extension and strengthening of State services, for the encouragement and assistance of community child-welfare organization, and for the development of additional local facilities, there are marked variations within this general framework, because of the variations among existing child-welfare programs. The proportionate amount of Federal funds used for State services and for providing direct services to children in local areas and the extent to which Federal funds are used to supplement State and local funds for child-welfare services in local areas vary from State to State.

It was never contemplated that the Federal funds for child-welfare services would be sufficient to aid in the development of services in all rural areas. Under this program local services have been developed on a demonstration basis to stimulate community support and more adequate community organization for child-welfare work and to provide practical experience that can be utilized in extending such services throughout the State. The workers in local areas are concerned primarily with the prevention of child dependency, neglect, and delinquency. They study the problems of the child who is referred to them by the school, the police, the juvenile court, or the family to determine what the child needs and to see whether arrangements can be made to meet his needs at home, at school, in the community, or if necessary in the hospital, the foster home, or the children's institution. In addition to direct service to children the local workers are concerned with stimulating community awareness of children's problems and organizing resources to deal with them.

Under the reporting plan the public-welfare agency administering the State plan for child-welfare services submits monthly reports on the number of children receiving case-work services from workers whose salaries or travel expenses are paid in whole or in part from Federal funds. The reports are received from workers in selected rural counties, in nonrural "areas of special need," and in units composed of several counties or towns. They cover those children for whom responsibility is accepted for continued study, treatment, and service.[1] The reports do not always include all the children receiving child-welfare services in a county or area, for there may be additional child-welfare workers paid from State or local funds whose services are similar to those of the workers paid from Federal funds. However, the plan provides for optional reporting by such workers, and 17 States submitted reports from these workers in August 1940. These optional reports are not included in the figures presented in this article.

In addition to the value that the reporting plan has as a means of interpreting programs for child-welfare services, it should aid in working out effective reporting procedures that will be applicable to all areas as more intensive service for children is extended throughout a State. One objective of the present reporting plan is the development of a system whereby reports covering all local units may be obtained from every State. Although in most States local child-welfare work is still in a pioneer stage, State welfare agencies are thinking in terms of programs that eventually will reach all children who are in need of special care and protection.

The form used in the reporting system for child-welfare services is similar to one used in the Children's Bureau project for the registration of social statistics in which 245 protective and foster-care agencies in 39 urban areas are participating.

AREAS IN WHICH FEDERAL FUNDS ARE USED FOR CHILD-WELFARE SERVICES

Before presenting the data obtained through the current reporting plan it is desirable to describe the extent of "coverage" of Federal funds for local child-welfare services throughout the country.

Of 735 professional workers whose salaries, as of June 30, 1940, were paid in whole or in part from Federal funds, 495 gave direct services in local communities, and 240 were engaged in "State services," including organization of community child-welfare activities, consultation to local workers, and specialized services related to the development of adequate care and protection for children.

Of the 495 workers in local areas, 445 were serving 512 counties, 11 were serving areas composed of a combination of towns or other local areas, and 39 were giving some case-work services to children in districts covering 652 counties as a part of their work in developing interest in the employment of a local child-welfare worker and in participation in a general child-welfare program. In addition, a large number of other areas were aided by the 240 workers engaged in "State services" through consultation and occasional case work.

The trend has been toward establishing services in single counties rather than in larger areas. Often it has been necessary to begin by providing one worker for two or more counties, or for a district composed of several counties, but this has been followed as soon as conditions permitted by a reduction in the size of the area per worker. In a few States child-welfare services have been coordinated with State statutory responsibilities and other general welfare service. In most States, however, the emphasis has been upon full-time service in one-county units by workers specializing on child-welfare problems.

Of the 512 counties receiving services through Federal funds on June 30, 1940, 507 were in continental United States. These included 486 rural counties, 15 nonrural "areas of special need," and 6 counties in which some services were provided through units organized for the orientation or training of prospective child-welfare workers. The accompanying map shows the distribution of

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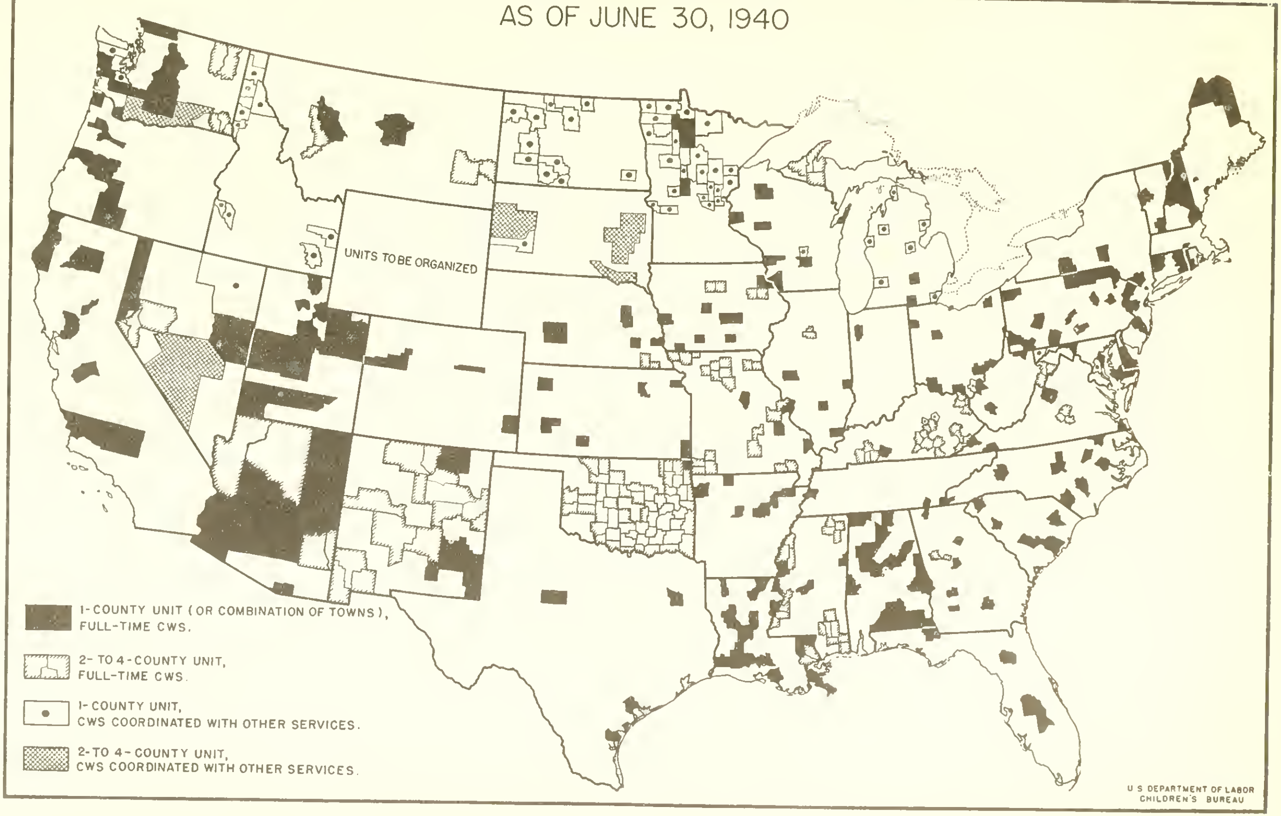
[1] Thus the reports exclude incidental services, investigations made for other agencies, and reports on closed cases.

RURAL AREAS IN WHICH FUNDS WERE AVAILABLE FOR CHILD-WELFARE SERVICES

AS OF JUNE 30, 1940


UNITS TO BE ORGANIZED
▇ 1-COUNTY UNIT (OR COMBINATION OF TOWNS), FULL-TIME CWS.
▨ 2- TO 4-COUNTY UNIT, FULL-TIME CWS.
☐ 1-COUNTY UNIT, CWS COORDINATED WITH OTHER SERVICES.
▩ 2-TO 4-COUNTY UNIT, CWS COORDINATED WITH OTHER SERVICES.
U S DEPARTMENT OF LABOR
CHILDREN'S BUREAU

rural areas in continental United States in which Federal funds were expended for a demonstration of child-welfare services and the method of organization in these areas on June 30, 1940. The number of one-county units and units comprising two to four counties in rural areas in which there were workers paid from Federal funds devoting their entire time to child-welfare services or workers combining child-welfare services with other services is as follows:

	Child-welfare services	
	On full-time basis	*Coordinated with other services*
One-county units	240	59
Two- to four-county units	167	20

The rural counties in which Federal funds were used for demonstration of child-welfare services as of June 30, 1940, comprised approximately one-fifth of the total number of counties classified as rural in continental United States. The extent of this program is a very important consideration in relation to the development of adequate social services for children. Private agencies in general confine their activities to cities. In small cities and rural areas responsibility rests almost entirely upon the local public-welfare departments.

CHILDREN RECEIVING SERVICES IN AUGUST 1940 FROM WORKERS PAID IN WHOLE OR IN PART FROM FEDERAL FUNDS

Under the recently established reporting plan 45 States, Alaska, and Hawaii submitted reports for August 1940. During that month 4,243 children were reported as accepted for service; a total of 41,109 children from 20,104 families were reported as receiving various forms of service in the States as of August 31 (table 1); and 3,232 were discharged during the month. Adding to the total reported as receiving services in 45 States, Alaska, and Hawaii an estimated number for the States not reporting, it appears that approximately 45,000 children were receiving services through the aid of Federal funds on August 31, 1940.

The most significant fact brought out by the figures on types of care is the preponderance in most States of children who receive service in their own homes as compared with those receiving foster care. Seventy-six percent of the total number of children under care in 45 States, Alaska, and Hawaii, on August 31, 1940, were in their own homes or those of relatives; 23 percent were receiving foster care; and 1 percent were under care elsewhere (table 1). Of the children receiving foster care, 47 percent were in boarding homes, 24 percent in free homes, 6 percent in work or wage homes, and 23 percent in child-caring institutions.

The data relating to types of service must be studied in the light of conditions in each State. In many States children in families receiving aid to dependent children or other public relief who need additional services because of particular problems may be referred to child-welfare workers for service. In several States foster care was already an established system under the local public-welfare departments when plans for child-welfare service under the Social Security Act were put in operation, and the amount of such care and its types reflect a continuance of supervision of children already in foster-family homes or institutions. In a few States emphasis is still placed upon providing for children who appear to need foster care to the probable exclusion of those needing other forms of service. In some States, however, where the percentages of children in foster care are high as compared with children given services in their own homes, this is due to selection of counties for demonstration purposes because of the special need for broadening the county welfare department's conception of child-welfare services. In certain other States foster care by the State department and by private agencies eliminates or reduces the need for direct provision of foster care by local public agencies.

Of the children receiving services in their own homes or the homes of relatives in 44 States,[2] Alaska, and Hawaii, 40 percent were members of families who were receiving no public assistance, whereas 60 percent were members of families who were receiving one or more forms of public assistance (table 2). This information, which shows that services are provided for children in families not receiving public assistance as well as

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[2] Data were incomplete for New Jersey, one of the 45 States reporting in August.

Table 1.--Children receiving child-welfare services by type of service, with families represented; 45 States and 2 Territories, August 31, 1940[a]

State	Families represented	Total children	Type of service received									
			Service in own home[b]		Foster care						Other	
			Number	Percent	Total		Boarding home	Free home[c]	Work or wage home	Institution	Number	Percent
					Number	Percent						
Total	20,104	41,109	31,277	76	9,324	23	4,409	2,252	554	2,109	508	1
Alaska	238	457	283	62	173	38	39	7	2	125	1	(d)
Arizona	627	1,209	919	76	228	19	115	74	17	22	62	5
Arkansas	350	649	448	69	193	30	128	44	8	13	8	1
California	254	746	598	80	135	18	107	7	4	17	13	2
Colorado	115	195	99	51	93	48	86	2	3	2	3	1
Connecticut	268	755	672	89	80	11	51	11	7	11	3	(d)
Delaware	291	448	130	29	310	69	230	73	7	0	8	2
Florida	262	588	506	86	77	13	26	18	2	31	5	1
Georgia	381	765	599	78	157	21	29	65	8	55	9	1
Hawaii	136	269	85	32	165	61	80	19	10	56	19	7
Idaho	241	504	405	80	85	17	45	20	17	3	14	3
Illinois	550	1,185	1,122	95	60	5	28	22	5	5	3	(d)
Indiana	49	91	29	32	60	66	21	5	4	30	2	2
Iowa	648	1,370	1,154	84	212	16	107	24	23	58	4	(d)
Kansas	558	1,056	585	55	462	44	17	238	40	167	9	1
Kentucky	674	1,017	622	61	372	37	42	285	1	44	23	2
Louisiana	674	1,320	1,108	84	212	16	117	35	1	59	0	......
Maine	56	132	110	83	20	15	16	1	3	0	2	2
Massachusetts	80	279	261	93	13	5	1	3	1	8	5	2
Michigan	561	970	795	82	171	18	62	69	18	22	4	(d)
Minnesota	2,506	4,532	3,783	83	722	16	241	199	48	234	27	1
Mississippi	360	828	719	87	49	6	8	32	3	6	60	7
Missouri	708	1,672	1,448	87	223	13	65	89	19	50	1	(d)
Montana	9	9	1	11	8	89	2	3	0	3	0	......
Nebraska	323	593	493	83	88	15	19	13	10	46	12	2
Nevada	212	448	381	85	58	13	28	14	5	11	9	2
New Hampshire	396	996	487	49	505	51	288	20	49	148	4	(d)
New Jersey	459	957	895	93	54	6	17	14	12	11	8	1
New Mexico	366	565	314	56	243	43	76	75	9	83	8	1
New York	394	782	359	46	415	53	226	31	11	147	8	1
North Carolina	338	576	393	68	168	29	27	99	8	34	15	3
North Dakota	663	1,882	1,784	95	92	5	44	6	22	20	6	(d)
Ohio	307	663	531	80	132	20	76	14	8	34	0	......
Oklahoma	646	1,408	1,136	81	263	18	138	72	23	30	9	1
Oregon	166	333	231	70	101	30	85	6	5	5	1	(d)
Pennsylvania	766	1,372	291	21	1,060	77	693	82	24	261	21	2
Rhode Island	108	349	343	98	6	2	2	0	2	2	0	......
South Carolina	382	923	798	87	122	13	41	31	7	43	3	(d)
South Dakota	228	411	333	81	62	15	23	19	8	12	16	4
Tennessee	518	991	720	73	245	25	88	61	17	79	26	2
Texas	622	1,304	1,067	82	227	17	70	101	6	50	10	1
Utah	515	1,431	1,393	97	26	2	18	3	0	5	12	1
Vermont	214	672	577	86	84	12	47	12	19	6	11	2
Virginia	642	1,095	574	53	497	45	342	120	7	28	24	2
Washington	659	1,082	759	70	312	29	248	23	16	25	11	1
West Virginia	138	259	191	74	63	24	24	27	8	4	5	2
Wisconsin	446	971	746	77	221	23	126	64	27	4	4	(d)

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[a] Includes only children receiving services from child-welfare workers paid in whole or in part from Federal funds under title V, part 3, of the Social Security Act.

[b] Includes children living in the homes of relatives.

[c] Includes prospective adoption homes.

[d] Less than one-half of 1 percent.

Table 2.--Children receiving child-welfare services in homes of parents or relatives, and percentage whose families received public assistance; 44 States and 2 Territories, August 31, 1940[a]

State	Children receiving child-welfare services in homes of parents or relatives						
	Total	Percent whose families received public assistance--					Percent whose families received no public assistance
		Of any type[b]	Type of assistance				
			Aid from public general relief or veterans' relief	Aid through WPA, CCC, NYA, FSA	Aid to dependent children	Other types	
Total..........	30,382	60	20	20	23	3	40
Alaska..............	283	55	4	(c)	49	2	45
Arizona.............	919	55	13	13	30	1	45
Arkansas............	448	59	9	17	30	5	41
California..........	598	85	20	12	60	4	15
Colorado............	99	64	13	18	28	5	36
Connecticut.........	672	45	39	23	0	3	55
Delaware............	130	30	18	1	7	5	70
Florida.............	506	50	9	13	31	3	50
Georgia.............	599	59	41	18	9	1	41
Hawaii..............	85	27	12	8	7	0	73
Idaho...............	405	59	10	27	22	0	41
Illinois............	1,122	83	29	29	29	1	17
Indiana.............	29	59	7	14	10	28	41
Iowa................	1,154	56	40	20	2	5	44
Kansas..............	585	74	45	26	24	3	26
Kentucky............	622	52	11	13	26	13	48
Louisiana...........	1,108	61	5	6	45	5	39
Maine...............	110	65	49	13	8	5	35
Massachusetts.......	261	41	28	9	8	2	59
Michigan............	795	52	13	17	24	2	48
Minnesota...........	3,783	63	24	24	14	2	37
Mississippi.........	719	28	1	19	5	6	72
Missouri............	1,448	66	19	24	22	2	34
Montana.............	1	0	0	0	0	0	100
Nebraska............	493	67	11	30	32	3	33
Nevada..............	381	52	12	33	6	1	48
New Hampshire.......	487	40	33	7	0	0	60
New Mexico..........	314	48	16	23	9	1	52
New York............	359	31	29	4	1	1	69
North Carolina......	393	60	9	11	37	3	40
North Dakota........	1,784	63	8	28	31	1	37
Ohio................	531	55	25	25	3	3	45
Oklahoma............	1,136	81	20	23	48	7	19
Oregon..............	231	82	32	5	41	4	18
Pennsylvania........	291	50	29	6	12	3	50
Rhode Island........	343	71	20	19	34	8	29
South Carolina......	798	43	1	18	24	2	57
South Dakota........	333	74	22	39	22	2	26
Tennessee...........	720	47	3	15	26	3	53
Texas...............	1,067	53	28	26	0	3	47
Utah................	1,393	78	11	17	54	2	22
Vermont.............	577	42	35	5	11	1	58
Virginia............	574	63	18	5	36	6	37
Washington..........	759	54	22	17	18	4	46
West Virginia.......	191	60	31	30	22	1	40
Wisconsin...........	746	61	28	29	8	3	39

[a] Complete data not available for New Jersey, one of the 45 States reporting in August 1940.

[b] These figures are based on unduplicated counts of children in families receiving some type of public assistance; in some instances families are reported as receiving more than one type of assistance.

[c] Not available.

in families receiving public assistance, is evidence that the acceptance of cases is based on the social and emotional needs of the child.

The foregoing data show the volume of casework services to children by local rural workers paid in whole or in part from Federal funds allotted for child-welfare services. The significance of these figures lies in the degree to which they reflect the need for specialized services for children at the place where the children live, and the extent to which the cooperative Federal, State, and local child-welfare program developed thus far on a demonstration basis has provided services for children in rural areas.

FOSTER CARE OF DEPENDENT AND NEGLECTED CHILDREN IN URBAN AREAS

One of the oldest and most generally respected types of welfare activity in the United States is the provision of foster care for children who have no homes or the conditions of whose homes are inimical to wholesome living. Until very recently, the history of this method of social treatment has been one of gradual expansion. By 1933 a Federal census enumerated approximately a quarter of a million children receiving various types of foster care.

Earlier reviews in this publication,[1] based, like the present article, on reports from urban areas only, have indicated that as late as 1937 the number of children receiving foster care was still increasing, although at a very slow rate. The program has manifested, however, a number of important changes, one of which has been the increase of foster-family care as an alternative to care in institutions. The shifting age distribution of the population and the development of other welfare activities have presaged additional changes. It is fortunate, therefore, that statistical material now available makes it possible to trace recent trends in the scope and nature of the foster-care program.

EXTENT OF FOSTER CARE

The 38 urban areas for which material is now available[2] reported on June 30, 1940, a total of 63,300 children under foster care, or an average of 8 children per 1,000 population under 21 (1930 census). These figures, and others presented here, are limited to children who are residents of the respective areas. The areas themselves, all with more than 100,000 population, include approximately one-third of the total urban population of the United States and are believed to be fairly representative of urban conditions but should not, of course, be taken as representative of the country as a whole.

Separate figures for the 38 areas are presented in table 3, and the ratios of children under foster care per 1,000 population under 21 are presented in figure 1.[3] It will be seen that while these ratios vary from 2 (Grand Rapids) to 16 (San Francisco), those of 20 areas are included in the range 6 to 10. An explanation of the differences in the ratios for the respective areas would require consideration of geographic, economic, and political factors, local traditions and personalities, and the general level of advancement of the community organizations for social welfare, including public foster-care programs.

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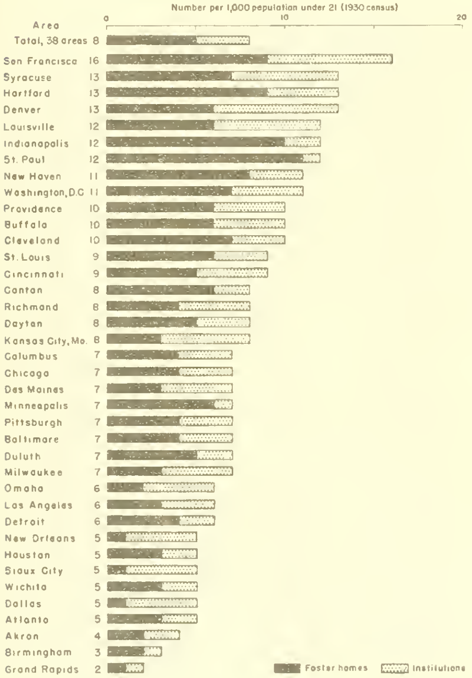
[1] Cf. issues of January 1937 and March 1938. Statistical data for 1937 were made available in the form of mimeographed tables, issued January 4, 1939.

[2] These areas participate in the social-statistics project, a cooperative project of the United States Children's Bureau and various local community chests and councils of social agencies, designed to develop uniform standards of statistical recording and reporting for urban health and welfare agencies. For the most part these areas include large cities and their environs; the boundaries of the areas are indicated in table 3, p. 16. All areas for which June 1940 material is given have submitted relatively complete reports, covering not less than 92 percent of children under foster care. Condensed summaries of such material for other months are issued regularly by the Division of Statistical Research of the Children's Bureau and will be supplied without charge on request.

[3] In view of the fact that these ratios are based on 1930 census data and that there is some variation in the completeness of reporting the number of children under foster care, minor differences cannot be considered to be significant.

Directly comparable data for earlier years are not available. Less complete but dependable material from 29 of these areas,[4] however, reveals that the number of children under foster care increased gradually from 1936 to 1938, but in 1939 showed a decrease. The extent of this decrease was not great, only 1 percent, but it is important since it may mark the end of a long period of expansion. As is indicated in the following figures the number of children under care was slightly greater in 1939 than in 1936:

Fig. 1.—NUMBER OF DEPENDENT AND NEGLECTED CHILDREN UNDER FOSTER CARE PER 1,000 POPULATION UNDER 21 YEARS OF AGE IN 38 URBAN AREAS, JUNE 30, 1940



Year	*Children under foster care as of Dec. 31*	*Percent change from preceding year*
1936	53,000	----
1937	54,700	+3
1938	55,700	+2
1939	55,200	-1

As would be expected, data for individual cities presented in table 4 reveal considerable variation in recent trends. Sixteen of the 29 cities, however, reported fewer children receiving foster care in 1939 than in 1938. Eleven reported fewer in 1939 than in 1936.

It is too early to conclude that the foster-care program in the United States has passed its peak. Data for later years may reveal a resumption of the previous upward trend in urban areas[5] or the decline of foster care in the cities may be offset by an increase in the rural areas. It is of interest to note, however, that important factors are operating which can be expected to reduce the scope of the foster-care program before the lapse of many more years. In the first place the child population (persons under 21), which reached its peak about 1930, is now decreasing and by 1945 will be about 8 percent below its highest level. In the second place, the rise of other types of welfare programs, including general family assistance, aid to dependent children, and daytime care of children, presents in many instances alternative means of dealing with family problems and reduces the need for foster care.

TYPE OF CARE

The present summary statistics afford but a crude indication of the type of foster care currently provided and the trends in type of care during recent years. Material at hand reveals, however, that 59 percent of the 63,300 children under care on June 30, 1940, were in foster families and only 41 percent were in institutions. About four-fifths of the children in foster families were in boarding homes, comparatively small numbers were in free homes or in work or wage homes (table 1 and fig. 2). The types of care provided varied considerably from one urban area to another. Foster-family care in some areas,

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[4] Statistics for past years are not available for 9 of the 38 areas submitting reports for June 1940. Reports for the 29 areas, although not in all cases as complete as reports for 1940, cover a very large proportion of all foster-care cases and include the same local agencies in each of the 4 years. Consequently they are believed to be dependable for indicating trends.

[5] Preliminary reports now available through October 1940, however, indicate a continuation of the downward movement during this year.

Table 1.—Dependent and neglected children under foster care in 38 urban areas, by auspices and by type of care, June 30, 1940

Type of care	Total		Public auspices		Private auspices	
	Number	Percent	Number	Percent	Number	Percent
Total........	63,332	100	21,692	100	41,640	100
In institutions...	25,676	41	3,222	15	22,454	54
In foster homes...	37,656	59	18,470	85	19,186	46
Boarding homes.	30,181	47	15,597	72	14,584	35
Free homes.....	5,058	8	1,748	8	3,310	8
Work or wage homes.........	2,417	4	1,125	5	1,292	3

namely, Indianapolis, Minneapolis, and St. Paul, accounted for 80 percent or more of all children under care; while other areas, including Dallas, New Orleans, and Sioux City, reported an almost equally large proportion in institutions (fig. 1).

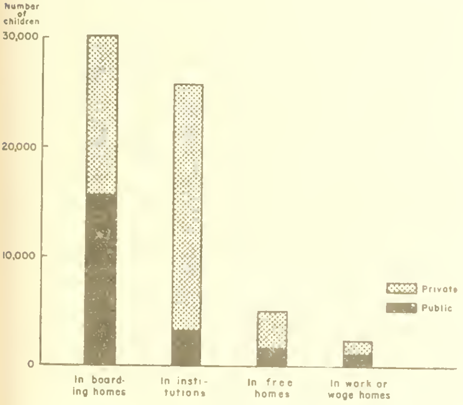
Judging from the more limited material available for the years 1936 to 1939 it appears that the proportion of children receiving foster-family care has been increasing slightly while the proportion receiving institutional care has gradually declined. This movement constitutes a continuation of a trend that has been apparent for decades. The percentages for the last 4 years are as follows:

Percentage of children under care Dec. 31

Year	*In foster families*	*In institutions*
1936	55	45
1937	56	44
1938	58	42
1939	59	41

Of the 29 areas reporting for all 4 years, 22 showed an increase in the number of children under care in foster families, but only 6 showed an increase in the number of children under care in institutions (fig. 3). Only 2 areas, Columbus and Dallas, reported an increase in the *percentage* of children under care who were in institutions.

Fig. 2.-TYPE OF FOSTER CARE PROVIDED FOR 63,300 DEPENDENT AND NEGLECTED CHILDREN IN 38 URBAN AREAS, JUNE 30, 1940



AUSPICES UNDER WHICH CARE WAS GIVEN

About two-thirds of the children receiving care in the 38 areas on June 30, 1940, were under care of private agencies, and only about one-third under care of public agencies. The proportion of children under public care, however, has increased slightly in recent years. Of the private agencies, the Catholic agencies were responsible for the largest number of children, 45 percent of all children under care. Nonsectarian agencies were second with 35 percent of all children; Protestant agencies were responsible for 13 percent; Jewish, for 6 percent; and other private agencies, for 1 percent.

It is of interest to note that institutional care is administered largely by private agencies. Thus, on June 30, 1940, fully 54 percent of all children under care of private agencies, but only 15 percent of the children under care of public agencies, were in institutions.

Statistics for individual areas reveal that in some places, notably Cincinnati, Detroit, and San Francisco, the foster-care program is administered entirely by private agencies. On the other hand, public agencies account for more than half of the children under care in 11 of the 38 areas reporting; namely, Akron, Cleveland, Dayton, Des

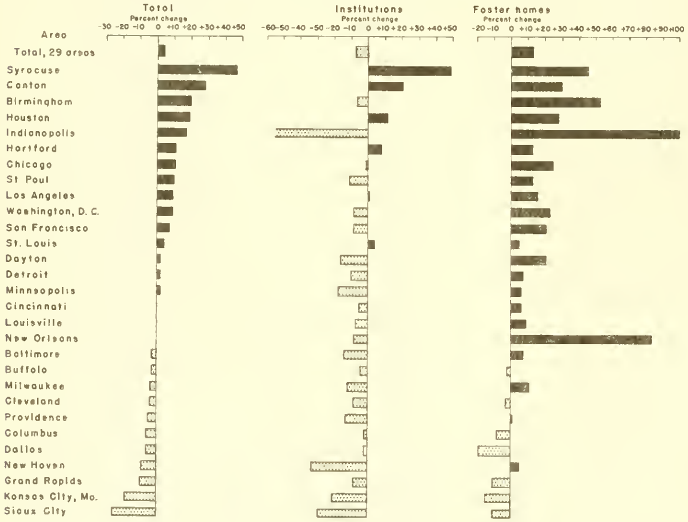
Table 2.—Total expenditures for protective and foster care of dependent and neglected children in 29 urban areas, by source of funds and auspices of agencies, 1938

Source of funds	Total		Public auspices		Private auspices	
	Amount	Percent	Amount	Percent	Amount	Percent
Total..............	$15,117,957	100	$5,109,887	34	$10,008,070	66
Public funds............	6,989,627	100	4,976,835	71	2,012,792	29
Private funds...........	7,071,007	100	16,868	(a)	7,054,139	100
Income from fees.........	1,057,323	100	116,184	11	941,139	89

[a] Less than one-half of 1 percent.

Moines, Duluth, Hartford, Indianapolis, Louisville, New Haven, Providence, and Washington, D.C.

Fig. 3.—PERCENTAGE INCREASE OR DECREASE IN NUMBER OF CHILDREN UNDER FOSTER CARE IN 29 URBAN AREAS FROM 1936 TO 1939



SOURCES OF FUNDS

A substantial part of the foster care provided through private agencies is actually paid for by public funds. Thus, in a recent year, although two-thirds of all expenditures for foster care in 29 urban areas were made by private agencies, the amounts contributed from tax funds and private charity were approximately equal.

The material presented in table 2 includes expenditures for both foster and protective care and is consequently somewhat broader in coverage than other statistical material presented in this article. Expenditures for protective care, however, form a minor part of the total and for present purposes their inclusion is not believed to result in any serious distortion of the picture. It is of interest, therefore, to note that in 29 areas[6] reporting such expenditures for 1938 the aggregate amount expended was slightly more than $15,000,000. This is equivalent to an expenditure of $1.04 per capita for the population of the areas. Approximately $10,000,000 was expended through private agencies, and public agencies expended slightly more than $5,000,000. Tax funds and private contributions each supplied, however, approximately $7,000,000; approximately $1,000,000 was paid in as fees by parents and relatives of the children receiving care.

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[6] These are not the same 29 areas for which trend material is presented elsewhere in this article. The financial statistics include Atlanta, Bridgeport, Richmond, Springfield (Mass.), Wichita, and Wilkes-Barre, but exclude Chicago, Detroit, Minneapolis, New Haven, St. Paul, and Sioux City. Twenty-three cities are common to both groups.

FOSTER CARE AND AID TO DEPENDENT CHILDREN

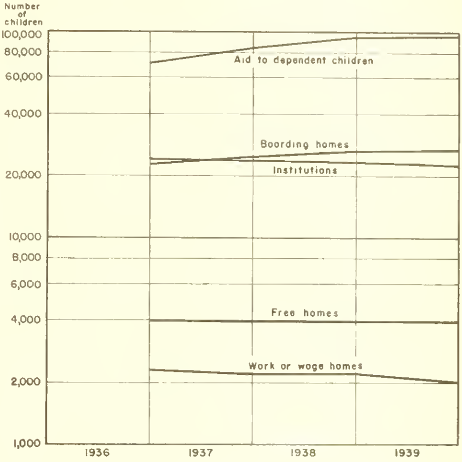
Unlike foster care, aid to dependent children is provided exclusively for the benefit of children living with parents or relatives. These two specialized children's services are therefore complementary, and it is of interest to compare them with respect to present magnitude and recent trend of development.

In the 38 cities combined, the number of children receiving aid to dependent children as of June 30, 1940, was 126,000, or exactly double the number under foster care. The relative importance of the two programs varied greatly from city to city, however, as is evident from table 3. In 6 areas, for example, the number of children receiving this assistance was more than 5 times as great as the number of children under foster care, whereas in 11 areas the number of children receiving assistance was smaller than the number under foster care.

The factors responsible for these differences are extremely complex and cannot be fully discussed here. It should be pointed out, however, that a number of the areas are in States that do not participate in the Federal program for aid to dependent children but instead operate State or local programs, usually identified as "mothers' aid programs."[7] Six of the 11 areas in which the foster-care program is more extensive than the program for aid to dependent children are of this type. On the other hand, in several areas that have not had funds for an ample foster-care program the availability of Federal funds on a matching basis has made possible a fairly extensive program for aid to dependent children.

Stimulated by Federal legislation and funds, the program for aid to dependent children has grown steadily in recent years, especially during the first years of the social-security program. In the 29 areas for which data are available, the number of children receiving assistance under the program for aid to dependent children increased 36 percent from December 31, 1936, to December 31, 1939. During the same period the total number of children under foster care increased only 4 percent, and even the number in boarding homes increased at a slower rate than the number of children receiving assistance (table 4 and fig. 4).

Fig. 4.- TRENDS IN AID TO DEPENDENT CHILDREN AND SPECIFIED TYPES OF FOSTER CARE PROVIDED TO DEPENDENT AND NEGLECTED CHILDREN IN 29 URBAN AREAS, 1936-39



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[7] Areas located in such States are Chicago, Dallas, Des Moines, Hartford, Houston, Louisville, New Haven, and Sioux City.

Table 3.--Dependent and neglected children under specified

Area	Territory included	Children receiving aid to dependent children	Children under foster care					
			Total number of children					
			Total	In institutions	In foster homes			
					Total	Boarding homes	Free homes	Work or wage homes
Total, 38 areas[a]....		126,422	63,332	25,676	37,656	30,181	5,058	2,417
Akron....................	County....	628	532	264	268	172	51	45
Atlanta..................	Area[b].....	1,629	685	309	376	322	48	6
Baltimore................	City......	10,998	1,998	777	1,221	1,130	69	22
Birmingham...............	County....	4,192	588	251	337	170	163	4
Buffalo..................	County....	2,747	2,901	1,067	1,834	1,718	71	45
Canton...................	County....	615	706	201	505	401	51	53
Chicago[c]................	County....	4,006	10,288	4,920	5,368	4,826	403	139
Cincinnati...............	County....	2,033	1,725	835	890	675	128	87
Cleveland................	County....	4,236	4,271	1,032	3,239	2,836	149	254
Columbus.................	County....	956	914	421	493	350	72	71
Dallas[c].................	County....	187	539	444	95	73	22	......
Dayton...................	County....	791	779	339	440	295	74	71
Denver...................	County....	4,237	1,167	595	572	72	421	79
Des Moines[c].............	County....	577	451	260	191	105	80	6
Detroit..................	County....	14,724	3,909	1,038	2,871	2,237	475	159
Duluth...................	County....	2,269	584	146	438	358	79	1
Grand Rapids.............	County....	2,085	162	73	89	44	38	7
Hartford[c]...............	Area[d].....	316	1,083	330	753	717	19	17
Houston[c]................	County....	......	716	354	362	330	19	13
Indianapolis.............	County....	4,443	1,738	346	1,392	1,142	194	56
Kansas City, Mo..........	County....	1,814	952	585	367	261	84	22
Los Angeles..............	County....	12,003	4,027	1,694	2,333	1,481	545	307
Louisville[c].............	County....	1,181	1,552	789	763	559	171	33
Milwaukee................	County....	4,563	1,792	1,039	753	398	211	144
Minneapolis..............	Area[e].....	[f]3,393	1,131	159	972	633	211	128
New Haven[c]..............	Area[g].....	474	927	256	671	628	32	11
New Orleans..............	Parish....	7,852	922	752	170	120	50	......
Omaha....................	County....	3,936	511	302	209	73	70	66
Pittsburgh...............	County....	11,814	3,948	1,646	2,302	1,977	215	110
Providence...............	City......	1,139	984	367	617	486	71	60
Richmond.................	City......	753	542	251	291	207	77	7
St. Louis................	Area[h].....	6,098	3,102	1,224	1,878	1,574	185	119
St. Paul.................	County....	1,893	1,218	134	1,084	808	181	95
San Francisco............	County....	[i]2,470	2,522	1,024	1,498	1,381	61	56
Sioux City[c].............	County....	459	185	143	42	21	19	2
Syracuse.................	Area[j].....	725	1,036	472	564	495	32	37
Washington, D. C.........	City......	2,873	2,012	744	1,268	1,054	138	76
Wichita..................	County....	1,313	233	93	140	52	79	9

[a] Fort Worth not included; area added beginning July 1940.

[b] Includes DeKalb and Fulton Counties.

[c] This area is in a State that does not participate in aid to dependent children under the Social Security Act.

[d] Includes city of Hartford and towns of Bloomfield, East Hartford, Newington, West Hartford, Wethersfield, and Windsor.

[e] Includes city of Minneapolis and village of Edina.

types of care in 38 urban areas by auspices, June 30, 1940

Children under foster care											
Public auspices						Private auspices					
Total	In institutions	In foster homes				Total	In institutions	In foster homes			
		Total	Boarding homes	Free homes	Work or wage homes			Total	Boarding homes	Free homes	Work or wage homes
21,692	3,222	18,470	15,597	1,748	1,125	41,640	22,454	19,186	14,584	3,310	1,292
325	200	125	67	33	25	207	64	143	105	18	20
241	......	241	223	14	4	444	309	135	99	34	2
35	......	35	......	34	1	1,963	777	1,186	1,130	35	21
200	2	198	72	124	2	388	249	139	98	39	2
1,395	......	1,395	1,325	44	26	1,506	1,067	439	393	27	19
331	201	130	76	25	29	375	......	375	325	26	24
1,732	128	1,604	1,492	11	101	8,556	4,792	3,764	3,334	392	38
......	......	......	......	......	......	1,725	835	890	675	128	87
2,544	......	2,544	2,300	64	180	1,727	1,032	695	536	85	74
454	176	278	246	28	4	460	245	215	104	44	67
131	84	47	47	......	......	408	360	48	26	22	......
442	218	224	121	42	61	337	121	216	174	32	10
398	98	300	......	300	......	769	497	272	72	121	79
240	181	59	32	27	......	211	79	132	73	53	6
......	......	......	......	......	......	3,909	1,038	2,871	2,237	475	159
427	......	427	358	69	......	157	146	11	......	10	1
23	23	......	......	......	......	139	50	89	44	38	7
647	146	501	483	2	16	436	184	252	234	17	1
211	159	52	39	4	9	505	195	310	291	15	4
1,184	157	1,027	852	142	33	554	189	365	290	52	23
212	80	132	132	......	......	740	505	235	129	84	22
1,455	35	1,420	1,139	56	225	2,572	1,659	913	342	489	82
924	290	634	452	153	29	628	499	129	107	18	4
684	485	199	104	44	51	1,108	554	554	294	167	93
324	......	324	259	53	12	807	159	648	374	158	116
631	102	529	516	7	6	296	154	142	112	25	5
100	15	85	81	4	......	822	737	85	39	46	......
115	52	63	14	......	49	396	250	146	59	70	17
1,874	54	1,820	1,686	88	46	2,074	1,592	482	291	127	64
573	100	473	394	45	34	411	267	144	92	26	26
146	47	99	95	4	......	396	204	192	112	73	7
1,320	......	1,320	1,191	91	38	1,782	1,224	558	383	94	81
580	......	580	468	74	38	638	134	504	340	107	57
......	......	......	......	......	......	2,522	1,024	1,498	1,381	61	56
58	25	33	13	18	2	127	118	9	8	1	......
420	......	420	381	15	24	616	472	144	114	17	13
1,302	161	1,141	934	132	75	710	583	127	120	6	1
14	3	11	5	1	5	219	90	129	47	78	4

[f] Figures for Minneapolis relate to county.

[g] Includes city of New Haven and towns of East Haven, Hamden, and West Haven.

[h] Includes city of St. Louis and St. Louis County.

[i] In San Francisco a significant number of these cases are known to have been committed to the care and custody of private child-caring agencies which furnish social case work and, occasionally, funds to supplement the public allowance.

[j] Includes city of Syracuse and villages of East Syracuse and Solvay.

Table 4.—Dependent and neglected children under specified types

Area	Children receiving aid to dependent children	Children under foster care						
		Total						Public auspices
		Total	In institutions	In foster homes				Total
				Total	Boarding homes	Free homes	Work or wage homes	
Total, 29 areas:								
1936..........	70,186	53,007	24,008	28,999	22,693	3,997	2,309	15,094
1937..........	82,652	54,688	23,814	30,874	24,655	3,998	2,221	16,073
1938..........	94,083	55,729	23,305	32,424	26,236	3,954	2,234	17,181
1939..........	95,799	55,202	22,421	32,781	26,768	3,972	2,041	17,754
Baltimore:								
1936..............	7,562	2,196	1,001	1,195	1,009	149	37	63
1937..............	10,185	2,196	985	1,211	1,029	133	49	45
1938..............	12,244	2,285	974	1,311	1,119	133	59	38
1939..............	10,978	2,140	859	1,281	1,184	80	17	35
Birmingham:								
1936..............	4,437	547	309	238	155	83	....	101
1937..............	4,115	571	330	241	148	93	....	111
1938..............	4,161	648	331	317	156	155	6	175
1939..............	3,786	656	292	364	191	170	3	208
Buffalo:								
1936..............	2,037	2,911	1,121	1,790	1,626	107	57	1,324
1937..............	2,202	2,900	1,208	1,692	1,547	93	52	1,242
1938..............	2,827	2,905	1,170	1,735	1,597	90	48	1,281
1939..............	2,735	2,829	1,074	1,755	1,644	72	39	1,341
Canton:								
1936..............	728	554	159	395	281	74	40	248
1937..............	722	627	162	465	348	79	38	268
1938..............	739	663	172	491	371	77	43	279
1939..............	728	708	193	515	415	52	48	328
Chicago:								
1936..............	3,527	9,336	5,073	4,263	3,478	513	272	1,001
1937..............	4,633	9,690	4,927	4,763	4,014	522	227	1,234
1938..............	4,157	10,418	5,098	5,320	4,654	440	226	1,575
1939..............	4,230	10,349	5,043	5,306	4,744	418	144	1,686
Cincinnati:								
1936..............	2,158	1,780	933	847	660	94	93	....
1937..............	1,703	1,941	998	943	745	113	85	....
1938..............	2,083	1,887	941	946	760	114	72	....
1939..............	1,700	1,782	887	895	691	116	88	....
Cleveland:								
1936..............	2,948	4,489	1,109	3,380	2,968	177	235	2,535
1937..............	3,925	4,437	1,095	3,342	3,013	139	190	2,559
1938..............	4,467	4,415	995	3,420	3,034	163	223	2,663
1939..............	4,328	4,306	1,020	3,286	2,896	154	236	2,529
Columbus:								
1936..............	1,014	977	447	530	366	101	63	510
1937..............	1,088	983	439	544	368	109	67	466
1938..............	1,170	903	458	445	314	70	61	434
1939..............	970	923	437	486	346	74	66	461
Dallas:								
1936..............	434	552	422	130	71	59	....	148
1937..............	338	606	444	162	110	52	....	150
1938..............	241	604	447	157	115	42	....	146
1939..............	208	518	413	105	80	24	1	124

of care by auspices in 29 urban areas on December 31, 1936-39

Children under foster care										
Public auspices					Private auspices					
In institutions	In foster homes				Total	In institutions	In foster homes			
	Total	Boarding homes	Free homes	Work or wage homes			Total	Boarding homes	Free homes	Work or wage homes
3,158	11,936	10,012	1,050	874	37,913	20,850	17,063	12,681	2,947	1,435
3,009	13,064	11,169	1,038	857	38,615	20,805	17,810	13,486	2,960	1,364
2,848	14,333	12,223	1,174	936	38,548	20,457	18,091	14,013	2,780	1,298
2,583	15,171	13,017	1,257	897	37,448	19,838	17,610	13,751	2,715	1,144
....	63	....	62	1	2,133	1,001	1,132	1,009	87	36
....	45	....	44	1	2,151	985	1,166	1,029	89	48
....	38	....	37	1	2,247	974	1,273	1,119	96	58
....	35	....	34	1	2,105	859	1,246	1,184	46	16
13	88	42	46	....	446	296	150	113	37	....
11	100	49	51	....	460	319	141	99	42	....
11	164	55	106	3	473	320	153	101	49	3
2	206	71	133	2	448	290	158	120	37	1
....	1,324	1,248	56	20	1,587	1,121	466	378	51	37
....	1,242	1,160	57	25	1,658	1,208	450	387	36	27
....	1,281	1,202	52	27	1,624	1,170	454	395	38	21
....	1,341	1,272	49	20	1,488	1,074	414	372	23	19
159	89	10	56	23	306	....	306	271	18	17
162	106	34	49	23	359	....	359	314	30	15
172	107	26	54	27	384	....	384	345	23	16
193	135	86	23	26	380	....	380	329	29	22
152	849	656	12	181	8,335	4,921	3,414	2,822	501	91
145	1,089	942	9	138	8,456	4,782	3,674	3,072	513	89
138	1,437	1,294	11	132	8,843	4,960	3,883	3,360	429	94
129	1,557	1,450	8	99	8,663	4,914	3,749	3,294	410	45
....	....	....	....	....	1,780	933	847	660	94	93
....	....	....	....	....	1,941	998	943	745	113	85
....	....	....	....	....	1,887	941	946	760	114	72
....	....	....	....	....	1,782	887	895	691	116	88
....	2,535	2,364	65	106	1,954	1,109	845	604	112	129
....	2,559	2,399	52	108	1,878	1,095	783	614	87	82
....	2,663	2,432	81	150	1,752	995	757	602	82	73
....	2,529	2,287	75	167	1,777	1,020	757	609	79	69
170	340	266	60	14	467	277	190	100	41	49
144	322	249	60	13	517	295	222	119	49	54
168	266	219	38	9	469	290	179	95	32	52
179	282	240	38	4	462	258	204	106	36	62
88	60	60	....	....	404	334	70	11	59	....
80	70	70	....	....	456	364	92	40	52	....
82	64	64	....	....	458	365	93	51	42	....
80	44	44	....	....	394	333	61	36	24	1

Table 4.—Dependent and neglected children under specified types of

Area	Children receiving aid to dependent children	Children under foster care						
		Total						Public auspices
		Total	In institutions	In foster homes				Total
				Total	Boarding homes	Free homes	Work or wage homes	
Dayton:								
1936	610	781	397	384	280	51	53	451
1937	972	773	382	391	284	51	56	445
1938	914	793	336	457	335	69	53	451
1939	822	797	332	465	336	79	50	431
Detroit:								
1936	15,108	3,724	1,098	2,626	1,837	547	242	....
1937	15,763	3,881	1,058	2,823	2,066	528	229	....
1938	16,203	3,880	998	2,882	2,163	510	209	....
1939	16,166	3,790	992	2,798	2,187	459	152	....
Grand Rapids:								
1936	1,509	200	99	101	36	58	7	19
1937	2,236	247	112	135	75	57	3	29
1938	2,124	222	97	125	73	51	1	28
1939	1,922	181	91	90	54	32	4	33
Hartford:								
1936	427	1,021	356	665	590	32	43	555
1937	408	1,047	348	699	631	30	38	560
1938	340	1,074	357	717	665	22	30	616
1939	339	1,134	386	748	702	22	24	676
Houston:								
1936	297	563	305	258	227	24	7	168
1937	....	574	309	265	228	26	11	176
1938	....	631	331	300	262	26	12	197
1939	....	672	341	331	310	14	7	222
Indianapolis:								
1936	138	1,483	794	689	480	146	63	694
1937	3,616	1,870	663	1,207	996	153	58	1,176
1938	4,266	1,838	570	1,268	1,036	168	64	1,158
1939	4,479	1,733	358	1,375	1,113	213	49	1,145
Kansas City, Mo.:								
1936	240	1,285	883	402	184	205	13	224
1937	317	1,303	871	432	254	158	20	268
1938	658	1,210	834	376	258	86	32	250
1939	1,111	1,037	697	340	241	80	19	234
Los Angeles:								
1936	7,172	3,932	1,846	2,086	1,425	359	302	1,144
1937	8,657	4,289	1,939	2,350	1,608	432	310	1,311
1938	10,237	4,304	1,851	2,453	1,639	484	330	1,450
1939	11,477	4,288	1,869	2,419	1,566	556	297	1,478
Louisville:								
1936	649	1,540	859	681	509	146	26	879
1937	586	1,487	845	642	418	184	40	834
1938	658	1,489	799	690	466	177	47	867
1939	766	1,541	798	743	545	171	27	896
Milwaukee:								
1936	3,935	1,877	1,193	684	317	171	196	656
1937	4,166	1,824	1,123	701	333	196	172	605
1938	4,529	1,802	1,084	718	328	214	176	598
1939	4,582	1,812	1,052	760	396	212	152	657

care by auspices in 29 urban areas on December 31, 1936-39—Continued

Children under foster care										
Public auspices					Private auspices					
In institutions	In foster homes				Total	In institutions	In foster homes			
	Total	Boarding homes	Free homes	Work or wage homes			Total	Boarding homes	Free homes	Work or wage homes
282	169	93	33	43	330	115	215	187	18	10
271	174	96	35	43	328	111	217	188	16	13
219	232	148	42	42	342	117	225	187	27	11
206	225	136	46	43	366	126	240	200	33	7
....	....	....	....	....	3,724	1,098	2,626	1,837	547	242
....	....	....	....	....	3,881	1,058	2,823	2,066	528	229
....	....	....	....	....	3,880	998	2,882	2,163	510	209
....	....	....	....	....	3,790	992	2,798	2,187	459	152
19	....	....	....	....	181	80	101	36	58	7
29	....	....	....	....	218	83	135	75	57	3
28	....	....	....	....	194	69	125	73	51	1
33	....	....	....	....	148	58	90	54	32	4
150	405	370	4	31	466	206	260	220	28	12
149	411	373	6	32	487	199	288	258	24	6
168	448	416	4	28	458	189	269	249	18	2
161	515	489	5	21	458	225	233	213	17	3
159	9	1	3	5	395	146	249	226	21	2
157	19	11	4	4	398	152	246	217	22	7
155	42	29	5	8	434	176	258	233	21	4
168	54	48	2	4	450	173	277	262	12	3
493	201	81	79	41	789	301	488	399	67	22
424	752	608	98	46	694	239	455	388	55	12
348	810	655	105	50	680	222	458	381	63	14
164	981	797	150	34	588	194	394	316	63	15
137	87	87	....	....	1,061	746	315	97	205	13
142	126	126	....	....	1,035	729	306	128	158	20
128	122	122	....	....	960	706	254	136	86	32
98	136	136	....	....	803	599	204	105	80	19
44	1,100	900	40	160	2,788	1,802	986	525	319	142
37	1,274	1,074	42	158	2,978	1,902	1,076	534	390	152
35	1,415	1,215	45	155	2,854	1,816	1,038	424	439	175
31	1,447	1,247	47	153	2,810	1,838	972	319	509	144
321	558	404	129	25	661	538	123	105	17	1
302	532	336	158	38	653	543	110	82	26	2
293	574	372	155	47	622	506	116	94	22	....
293	603	427	152	24	645	505	140	118	19	3
541	115	9	34	72	1,221	652	569	308	137	124
485	120	9	41	70	1,219	638	581	324	155	102
463	135	9	54	72	1,204	621	583	319	160	104
463	194	89	43	62	1,155	589	566	307	169	90

Table 4.—Dependent and neglected children under specified types of

Area	Children receiving aid to dependent children	Children under foster care						
		Total						Public auspices
				In foster homes				
		Total	In institutions	Total	Boarding homes	Free homes	Work or wage homes	Total
Minneapolis:								
1936...............	[a] 2,168	1,138	212	926	590	206	130	209
1937...............	[a] 2,056	1,149	208	941	585	199	157	209
1938...............	[a] 2,695	1,134	175	959	645	195	119	246
1939...............	[a] 3,275	1,157	177	980	650	204	126	307
New Haven:								
1936...............	532	979	355	624	585	17	22	531
1937...............	528	957	319	638	603	13	22	551
1938...............	519	912	265	647	618	19	10	591
1939...............	491	891	238	653	617	26	10	612
New Orleans:								
1936...............	4,124	1,002	911	91	43	38	10	9
1937...............	5,570	965	869	96	52	39	5	11
1938...............	6,228	1,045	917	128	84	42	2	53
1939...............	7,103	1,002	835	167	106	59	2	80
Providence:								
1936...............	781	1,009	424	585	478	67	40	545
1937...............	992	1,055	467	588	477	63	48	577
1938...............	1,000	1,010	417	593	468	70	55	576
1939...............	1,122	959	369	590	452	77	61	536
St. Louis:								
1936...............	695	2,930	1,179	1,751	1,443	156	152	1,199
1937...............	493	2,872	1,195	1,677	1,417	142	118	1,203
1938...............	3,504	2,958	1,208	1,750	1,478	148	124	1,262
1939...............	4,381	3,060	1,221	1,839	1,540	182	117	1,300
St. Paul:								
1936...............	978	1,070	142	928	655	183	90	386
1937...............	925	1,179	129	1,050	765	187	98	478
1938...............	1,312	1,185	134	1,051	814	165	72	533
1939...............	1,722	1,178	127	1,051	789	175	87	554
San Francisco:								
1936...............	[b] 1,734	2,277	1,066	1,211	1,086	59	66	....
1937...............	[b] 2,036	2, 18	1,045	1,273	1,145	57	71	....
1938...............	[b] 2,322	2,371	990	1,381	1,244	59	78	....
1939...............	[b] 2,360	2,438	979	1,459	1,308	60	91	....
Sioux City:								
1936...............	315	231	193	38	13	25	....	65
1937...............	395	200	166	34	19	15	....	64
1938...............	469	199	143	56	33	17	6	85
1939...............	439	172	138	34	21	11	2	53
Syracuse:								
1936...............	276	766	307	459	408	34	17	322
1937...............	271	801	344	457	417	26	14	320
1938...............	736	1,012	451	561	504	29	28	423
1939...............	742	1,126	456	670	593	36	41	528
Washington, D. C.:								
1936...............	3,653	1,857	815	1,042	893	116	33	1,108
1937...............	3,754	1,946	834	1,112	960	109	43	1,181
1938...............	3,280	1,932	762	1,170	1,003	119	48	1,206
1939...............	2,837	2,023	747	1,276	1,051	144	81	1,300

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[a] Figures for Minneapolis relate to county.

[b] In San Francisco a significant number of these cases are known to have been committed to the care

care by auspices in 29 urban areas on December 31, 1936-39--Continued

Children under foster care										
Public auspices					Private auspices					
In institutions	In foster homes				Total	In institutions	In foster homes			
	Total	Boarding homes	Free homes	Work or wage homes			Total	Boarding homes	Free homes	Work or wage homes
....	209	188	20	1	929	212	717	402	186	129
....	209	190	18	1	940	208	732	395	181	156
....	246	222	23	1	888	175	713	423	172	118
....	307	249	48	10	850	177	673	401	156	116
127	404	394	2	8	448	228	220	191	15	14
122	429	422	3	4	406	197	209	181	10	18
110	481	472	4	5	321	155	166	146	15	5
104	508	496	7	5	279	134	145	121	19	5
9	....	....	....	....	993	902	91	43	38	10
11	....	....	....	....	954	858	96	52	39	5
19	34	34	....	....	992	898	94	50	42	2
13	67	57	10	....	922	822	100	49	49	2
113	432	374	36	22	464	311	153	104	31	18
137	440	379	32	29	478	330	148	98	31	19
127	449	374	44	31	434	290	144	94	26	24
90	446	364	49	33	423	279	144	88	28	28
....	1,199	1,045	85	69	1,731	1,179	552	398	71	83
....	1,203	1,090	68	45	1,669	1,195	474	327	74	73
....	1,262	1,131	87	44	1,696	1,208	488	347	61	80
....	1,300	1,170	92	38	1,760	1,221	539	370	90	79
....	386	300	74	12	684	142	542	355	109	78
....	478	375	77	26	701	129	572	390	110	72
....	533	428	77	28	652	134	518	386	88	44
....	554	434	82	38	624	127	497	355	93	49
....	....	....	....	....	2,277	1,066	1,211	1,086	59	66
....	....	....	....	....	2,318	1,045	1,273	1,145	57	71
....	....	....	....	....	2,371	990	1,381	1,244	59	78
....	....	....	....	....	2,438	979	1,459	1,308	60	91
27	38	13	25	....	166	166	....	....	....	....
30	34	19	15	....	136	136	....	....	....	....
29	56	33	17	6	114	114	....	....	....	....
25	28	16	10	2	119	113	6	5	1	....
....	322	298	17	7	444	307	137	110	17	10
....	320	296	14	10	481	344	137	121	12	4
....	423	382	18	23	589	451	138	122	11	5
....	528	477	20	31	598	456	142	116	16	10
154	954	809	112	33	749	661	88	84	4	....
171	1,010	862	105	43	765	663	102	98	4	....
155	1,051	889	115	47	726	607	119	114	4	1
151	1,149	935	134	80	723	596	127	116	10	1

and custody of private child-caring agencies which furnish social case work and, occasionally, funds to supplement the public allowance.

Published under authority of Public Resolution No. 57, approved May 11, 1922 (42 Stat. 541), as amended by section 307 Public Act 212, approved June 30, 1932 (47 Stat. 409). This publication approved by the Director, Bureau of the Budget, May 12, 1936.

U. S. GOVERNMENT PRINTING OFFICE : 1941

the CHILD

+++ Monthly Bulletin +++

The Merit System, Essential and Economic

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Care of Children With Heart Disease

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Children in a Democracy—

Following up the White House Conference

Report of the White House Conference as It Relates to the Delinquency Field

☆ ☆ ☆

Advisory Committee Recommendations—

Maternal and Child Health Services

Community Child Welfare Services

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

JANUARY 1941

THE CHILD MONTHLY BULLETIN

Volume 5, Number 7 January 1941

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The Children's Bureau does not necessarily endorse or assume responsibility for the statements or opinions of contributors not connected with the Bureau.

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The Merit System, Essential and Economic [1]

By George W. Cox, M. D.

State Health Officer, Texas State Board of Health

IN CONFORMITY with the 1939 amendment to the Social Security Act by the Congress of the United States and in the absence of a civil-service system in Texas, the State Board of Health, on March 11, 1940, adopted a system of policies to govern the operation of a merit system for Texas. This plan will apply to every service wherein funds provided by the State Department of Health are expended. It will not, however, conflict with any existing civil-service system locally. The plan will be instituted as soon as approval of all agencies is obtained. The action by the State Board of Health, it is believed, will contribute more to the quality of service, to economy in government, and to the security of public-health workers than any other action in its history.

A number of factors are responsible for the increased attention given to public employment. The tremendous expansion of the scope of government activities and the accompanying increase in public expenditures have led to a reawakened interest in government and therefore in public personnel. Again, the increasingly technical character of the duties performed has resulted in the employment of a greater number of professional and scientific persons who cannot without violence to the nature of their duties be made subject to political changes. Further, improvement of personnel management in private business has developed a system with which in some respects public employment has compared unfavorably. Important also as a factor has been the depression, which necessitated a reduction of public expenditures and has led to a reconsideration of personnel since outlays for this purpose constitute the largest single item of operating costs. In addition, many individuals formerly safely anchored in private business have found themselves without work and consequently have turned to the various units of government as a possible source of employment. This fact is shown most clearly by the tremendous increase in the number of applicants for positions in public service.

Although the development of public thinking on public personnel in this country has received considerable organized attention, it will be well if we note briefly the major changes which have occurred. Introduced at an early time, the spoils system implies the selection of public servants on the basis of party service with tenure dependent on the continuance of the particular party or political leader in power. This policy continues its grip on the public personnel of many jurisdictions and may be said to characterize the personnel policies of many State departments at the present time. It goes almost without saying that the spoils system negates virtually every principle of sound personnel administration.

The movement for the merit system has come largely as a result of a reaction in public thinking against the excesses of the spoils system. Because of the necessities surrounding the birth of this reform movement, it is only natural that emphasis must be placed on securing uninterrupted tenure and public service through the agency of a nonpartisan merit system. Periodic examinations and limits of protection to the more elementary positions have heretofore formed the basis of the movement. The main purpose was to prevent the unwarranted dismissal of public employees rather than to obtain and train the proper personnel. Today we need a broad scope of understanding relative to what constitutes a true merit system. It is true that it is necessary to continue to place emphasis on tenure, but we must adopt at the same time a more vigorous policy of training and supervising those engaged in public activities.

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[1] Paper read before meeting of Texas Public Health Association, Fort Worth, Oct. 1, 1940.

A review of public personnel administration reveals a woeful lack of application of the principles of the merit system in the several political jurisdictions. Our State government has no civil-service commission; and only one department, namely, the Department of Public Safety, has been directed by statute to install a merit system. A survey of the State government has summarized this deficiency in personnel administration, and I quote from its report: "Preposterous as it will seem a few years hence and deplorable as it is now, it is nevertheless a fact that the people of Texas have put no law on the statute books establishing the principle and the requirement that when a public position is to be filled, it must be filled by a person chosen because of his qualifications to perform the duties involved. The question of personnel cannot possibly be separated from the question of organization for good administration. The requirements of sound organization, effective procedure, and a competent personnel loyal to the public interest are closely related, but the third is the most important of the three; it is fundamental."

I am convinced that the safety of democracy and its survival in this country rest upon the assurance that our government procedures shall be placed in the hands of individuals possessing both capacity and character. This would obviously remove the danger of perpetuating unintelligent and autocratic bureaucracies and would replace them with living and responsible public-service agencies genuinely devoted to common welfare. This type of personnel is less likely to be obtained through the operation of the spoils and patronage system than through a nonpartisan method of recruitment based primarily on merit and required entrance qualifications. This, reinforced by a systematic program of in-service training (that is, for personnel already in service), will go far in increasing the individual citizen's confidence in, and understanding of, the functions of his government departments. Much has been written and said of late about the "career" in public service. Such a career of service will not exist in any department of our State government, generally speaking, until the tenure of position is made reasonably secure and the compensation paid is commensurate with the duties performed. The foregoing factors must be implemented with a continuous and systematic type of in-service training program so designed as to keep our personnel alert and striving to improve the quality of service they are called upon to render. With the financial assistance of cooperating Federal agencies and the hearty approval of our State Board of Health, this ideal has been made the preeminent cornerstone about which I have endeavored to build our public-health structure during the past 4 years. My faith and hope for the continued future program of public health in Texas is grounded upon the strength found in well-trained personnel of capacity and character.

Development of a career service depends largely on the extent to which a merit system has been adopted. Certain conditions are necessary as prerequisites to the installation of a career service and should be considered, as follows:

1. A definite legal basis.
2. An agency responsible for the advancement of the career system.
3. Entrance to the service based entirely upon the capacities of the individual.
4. Entrance in most instances limited to younger candidates and correlated with the educational system of the Nation.
5. Opportunities for advancement and promotion.
6. An equitable policy of remuneration.
7. Sound retirement policies.
8. The elimination of discharges or demotions for personal, religious, or political reasons.
9. A unified and vigorous support for the development of the career system as contained in a true merit system.

The stability of a departmental merit system demands that it have an adequate legal foundation. Partisan attacks against the merit plan may be repelled if it rests on the proper legal basis, which will serve at the same time to outline the general scope of the civil-service system. This assumes a special import when it is realized that the excellence of the merit system can rise no higher than the level permitted by law. Early legislation was designed to provide a defense against the spoilsmen and hence is largely negative in character. These legal provisions must be drawn in such a manner as to present the general principles of a correct system, yet at the same time be possessed of sufficient flexibility to permit the agency to exercise the power regarded as essential to the operation of a comprehensive civil-service program.

The personnel of the State Department of Health should be chosen on the basis of fitness for the work to be done, whether it is of supervisory, technical, or routine character. The best plan of organization structure is merely the design of the machinery through which the personal efforts of those who make up the service and give life to the organization can be given effect. There must be continuity of operating management within the organization and its several departments. If the gains and lessons of each month and year in the perfecting of organization and of internal operating policies and procedures are not to be made cumulative, greatly excessive costs of operation will result. There is a heavy investment involved in the staff of the State Department of Health in training and experience that has already been secured, in lessons that have been learned from failures and successes. Upon the division and bureau heads in particular depends the responsibility for carrying on from month to month and year to year. A high price is paid by the taxpayers when frequent changes are made without provision for carrying over the benefits of the acquired knowledge and experience.

In regard to service to the public, the merit system applied to the State Department of Health would gain certain practical results. In the first place, it would mean that the department would have in its service its share of the best character and capacity of the Nation. Our State government is securing high-grade teachers, engineers, stenographers, clerks, accountants, and similar professional and skilled groups. The influence of the merit system would make itself felt all the way down the line, not only in better administration but also in toning up the service because of the hope of advancement through good work rather than through favoritism. The merit system not only will cut costs but will give to the people the benefits of impartial and effective service.

In the second place, the employees of the State Department of Health would gain tremendously under the merit-system program. There would be a career in public service; young men and women of promise would know how to prepare themselves so that they could enter the field of public health and receive advancement in a fair competitive system. Although remuneration at present may not be so high as in some private services, it should be made sufficient to attract persons of capacity and ability who are seeking a career service. Such an employee would have the esteem of the public and the tremendous satisfaction of knowing that he or she is serving the public and that good and able service will be rewarded. The handing out of illegitimate special privileges brings keen suffering to any administrator, and to be freed of this will enhance the value of public employment immensely.

Under the influence and guidance of the merit system, employment in the State Department of Health would be treated as a career ladder and not as a fixed system of pigeonholes into which men are fitted. Examinations would be geared to the career program and applicants sought out. Tests would be made more for their brains and promise than for a special minor skill that would fit them for some special niche where they might be placed and forgotten. This can be accomplished under a merit system which provides a positive career service under modern personnel administration.

Establishment of a career service based on merit would do much to change the attitude of educational institutions toward arranging courses of study to fit students for entrance to public service. Under present conditions the schools and colleges have made little effort to understand or explain the constructive work of government departments or to picture the opportunities of public service. Educational institutions have hesitated to encourage students to enter public service, in the belief that favoritism has left no room for a career and that admission to low-grade positions takes no account of high qualifications.

In the field of public health, since the inception of our training program under the Federal Social Security Act, much has been done to revolutionize certain courses in some of the leading colleges and universities of America. With the establishment of admission on basis of merit in all government departments and the greater opportunity for career service, fuller cooperation would be attainable.

The merit system is the most effective means for carrying out the decisions and desires of the people. In fact, without effective personnel it may well be doubted whether it is possible for democracy to continue. Texas has been a State of great plans, only too often followed by no commensurable results. We have adopted programs to improve working conditions, to eliminate ruinous competition, to secure a fair distribution of work, leisure, and wealth, to control liquor consumption, to plan cities, to improve housing, to purify drugs and foods, to regulate utilities, to control money and banking, and to distribute taxes on the basis of capacity to pay, but in many fields we must in all honesty admit that our administrative achievements have left much to be desired. One of the fallacies of our government structure rests directly upon the lack of competent manpower to administer our programs and bring our plans to realization.

The activities of the State Department of Health now touch every citizen of this State in many ways. Each time the contact is through one of our personnel. If these contacts are skillful, intelligent, responsible, honest, impartial, and in accordance with law, and open to and influenced by criticism, we shall enjoy the privilege of seeing a truly effective program of public health being carried on which will be pleasing to the citizenship of Texas. If these contacts are arbitrary, bungling, dishonest, irresponsible, contrary to law, and beyond or shielded from criticism, our public-health program must bear the consequences. The very existence of the department of public health is conditioned by the quality and character of its personnel. The development of a career service is therefore essential to the present and future program of public health in Texas.

If I were called upon to say what the greatest structural need of the Texas State Department of Health is today, I believe I would be forced to admit that it is a stable merit system in the employment of personnel. The practical methods of proceeding to this end are: First, the development of concerted public opinion; second, the adoption of legislation, organization, and procedures which will establish careers in the department; and, third, the sustained and adequate administration of these provisions.

The nature of this program for transforming the work of the department to a career basis, while of the most far-reaching importance in the development of services to the people, is none the less relatively simple, easy to understand and execute, and thoroughly practical. The program fits the Constitution of our State and is in line with our system of government. It requires no type of structural change which we have not already tried out in practical experience. This program is tied in with the educational system, drawing young men and women from the existing colleges and professional and technical institutions. It recognizes the fundamental differences in individuals and the characteristics of human material as analyzed by science and experience. It is impartial, it is nonpartisan, it is nonpolitical, it is economical, and it is essential; it follows the lead of successful private business by making the most of science, technology, specialization, and the division of labor. It is designed to furnish the best available personnel to carry on the work of the State Department of Health, whatever the department's program may be.

Care of Children With Heart Disease

A New Development in the Crippled Children's Programs

By Robert C. Hood, M. D.

Director, Crippled Children's Division, U. S. Children's Bureau

During the first 5 years of experience in the administration of services for crippled children, children needing orthopedic or plastic surgery received major attention and care. It is realized that children have many other types of physical handicaps for which Nation-wide provision has not, as yet, been made. During the present fiscal year the Children's Bureau has allocated part of the additional Federal funds made available by the amendment to the Social Security Act in 1939 for the purpose of helping the States to develop services for children with heart disease and conditions leading to heart disease, such as rheumatic fever. This is a significant step in the expansion of medical-care programs for children. The devastating effects of rheumatic fever make this disease a public-health problem of major importance.

The basic principles and many of the techniques that have been developed in care of children requiring treatment for orthopedic and plastic conditions apply equally to the care of children with heart disease. The same insistence is placed on quality of service, the full range of essential services, and adequacy of facilities. With the small funds available during the initial stages of the cardiac program, State-wide services are not being established; services are being restricted to a limited area where children can be cared for satisfactorily. When the problems of a small number of children have been studied and care of high quality has been provided for them, it should be possible to extend services to other centers of a State as funds and facilities permit.

Nine States and the District of Columbia included cardiac programs in their 1941 plans of services for crippled children. Oklahoma was the first State to initiate care for children with heart disease and conditions leading to heart disease through the extension of services made possible by the additional grants; the others are California, Connecticut, Iowa, Maine, Maryland, Utah, Virginia, and the State of Washington. It is anticipated that these programs will bring under care hundreds of children for whom little provision has been made in the past.

The Children's Bureau, in consultation with advisory committees made up of experts in the various professional fields involved, has formulated recommendations concerning the administration of the programs, qualifications of professional personnel, and acceptable standards for facilities, such as hospitals and convalescent homes, to be used in the programs. Because the problem of infection in childhood is of major importance in planning for the treatment of rheumatic fever, the programs are being directed and medical services rendered by qualified pediatricians. Services of well-trained medical social workers and public-health nurses are also provided.

Many social problems are created by chronic, recurrent childhood infections such as rheumatic fever. These programs have a social as well as a medical purpose. Not only are services for children directed toward the prevention, so far as possible, of serious damage to the heart, but also efforts are made to guard against the development of social disability. The restrictions imposed by such a disease produce many problems that affect the satisfactory social adjustment of a child. The article following, by Miss Cohen, brings out some of the social factors involved in planning for the care of children in these programs.

Social Planning for Children With Rheumatic Heart Disease

By Ethel Cohen

Director, Social Service Department, Beth Israel Hospital, Boston, Mass.

In approving the extension of State services for crippled children to children with rheumatic fever and rheumatic heart disease, the United States Children's Bureau has given official recognition to one of the most serious problems of the national health.

Statistical studies made in various sections of the country give some indication of the great numbers of children affected by rheumatic infection and other conditions leading to heart disease, in some cases no less crippling than orthopedic defects of muscular and bone development. Undoubtedly there are a very large number of children with rheumatic infections not included in these statistical studies, who have not reached the attention of physicians. Rheumatic infection may exist completely unrecognized for years. Insurance and other health examinations have revealed rheumatic heart disease in adults who were completely unaware that they had ever had rheumatic fever. With early and proper care a great number of sick children may be safeguarded from seriously disabling handicaps.

For these children the first and most important essential is adequate medical diagnostic service. The types of treatment depend on the individual medical situation. For some children several examinations in the clinic will be needed. When the diagnostic problem is more difficult, hospital care will be required for close observation, for additional laboratory tests, and often for the opinion of other consultants. A correct diagnosis is of the utmost importance. Years of invalidism for children and worry and financial strain for their families can be prevented if the fact can be established that no disease exists. This is no less important than the confirmation of a definite diagnosis.

Children with acute rheumatic infection or heart disease need care in a hospital where intensive, expert medical and nursing supervision is available for periods ranging from several weeks to many months. When the acute phase of the illness has passed but infection is still present, the child will need long periods of rest in bed. Furthermore, he needs bed care until all clinical and laboratory evidence of infection has disappeared. This complete rest usually means that the child is not allowed to leave his bed for the bathroom or the dining room. However, during this period less intensive medical and nursing care will be required. A general hospital will not be the most desirable place for the child at this stage. From the community point of view it is inadvisable because of the high cost of hospitalization and the shortage of beds for patients with acute illnesses. From the patient's point of view discharge from a general hospital is advised as promptly as possible because of the danger of cross infection from patients with other acute illnesses.

Bed rest when prolonged becomes one of the most difficult aspects of care. Several possibilities may be considered—the child's own home, a foster home, or an institution. There are diverse types of institutions with some variation in the facilities they have to offer. Some are called convalescent homes, others are designated chronic hospitals or sanatoria and are organized solely for the treatment of rheumatic fever and rheumatic heart disease.

The choice of one of these alternatives will depend upon more than the medical picture. Many other factors are involved. The way the child feels about his illness and enforced long-time bed rest; the intelligence and emotional stability of other members of the family and their attitude toward the patient; the health of others in the home; the housing conditions; the size of the home in relation to the number in the household; the availability of individuals capable of giving the child constant care and supervising his daily routine; their capacity to understand the needs of a sick child and make adaptations for his comfort and happiness; their willingness to maintain the prescription for bed rest in the absence of outward physical disability; financial sufficiency for the provision of proper diet; availability of recreational and educational facilities; and accessibility of continuous and expert medical and nursing services; all these social elements are inherent in the problem of medical care.

These and many other considerations will be based on a knowledge of the circumstances of each patient attained through medical social personnel trained to observe and evaluate social data and to relate them to the medical situation.

It has been generally accepted that the child thrives best within his own family. In a normal home the child is wanted and loved, and the security thus attained stimulates his personal development and his social adaptations and achievements. On the assumption that the child's best chances for development are in his own home this would naturally be the first choice, provided the basic facilities needed for his care were available there. With the best will in the world on the part of the family the difficulties inherent in the care of children with heart disease are too great for many families. The continuous physical care, the time, resourcefulness, and patience needed to divert and keep the child content to rest when often there is no visible evidence of disease, the disorganizing effect on the lives of the others in the household are factors which overwhelm many a family and result in poor care of the patient.

The medical social worker can often anticipate such a situation by her knowledge of the child and his circumstances. When home care is known to be ill-advised or breaks down after having been undertaken, other arrangements will be necessary, and the advantages or disadvantages of other community resources will have to be weighed for each child.

Foster homes offer the best substitute for the child's own home in the possibilities they hold for the preservation of the constructive values of family life. However, it is often difficult to find satisfactory homes with understanding foster parents who are willing to accept sick children requiring specialized and constant attention or supervision. Foster-home care, a serious undertaking with well children, becomes a heavy responsibility when it involves the possible recurrence of cardiac illness, protection against respiratory and other infections, periodic visits to doctor or clinic, and the possibility of jealous rivalry from anxious, overprotective parents. For the child, hazards exist even when the foster home is excellent. For example, his transfer from intelligent foster parents and a comfortable foster home, where he has had pets and has received various little attentions, to a tenement home and overworked or irresponsible parents is full of potential problems.

The institutional type of care, in what is described variously as a sanatorium, residential school, or chronic hospital, has some very distinct advantages. Expert medical and nursing care and recreational and educational facilities are available. The child is one among many learning the significance of good hygiene, of balanced and correct diet, and the discreet direction of energy into productive channels, both while at complete bed rest and while he is gradually resuming activity under a careful regimen. Such institutions, to be adequate, should have personnel who are trained to appreciate the emotional and mental needs of growing children and who can compensate to the children for the values lost by separation from father and mother.

While the child is away in hospital, foster home, or institution for long-time care, opportunities should be provided for the education of the family in the proper care of the child. This may be done during the family's visits to the child and through the services of social and nursing agencies in the home. Children and parents alike need to be kept aware of the child's future homecoming, even if it is not possible for several years; one of the greatest disadvantages of institutional life is the ease with which some children become adapted to it and the subsequent difficulties of adjustment to life in the community. Likewise, families become accustomed to the long absence of the child, for life with its changes flows along in the home without this child.

Hardships may be experienced not only by the patient but by his brothers and sisters when he is reintroduced into a scheme of things to which he has become a stranger. The transfer from a pleasant, well-planned, smoothly running institution, with good, ample food attractively served, to a crowded, untidy, impoverished, noisy home may be too much of a strain for any but the hardiest child.

Much is involved for the child's normal development in a choice among the alternatives for care. The decision can be made neither casually nor by any rule of thumb. It can most safely be accomplished when medical social workers collaborating with physicians and nurses have coordinated all information about the home and the child known by all the persons familiar with them.

These children and their families are subject to the same vicissitudes of life as are all other children and families, with the added disabilities that are inherent in a long-continuing recurrent infection which often results in heart damage.

Furthermore, rheumatic infection is a problem of the whole family because of its frequent incidence in several members of a family. Whether this is due to exposure to the same predisposing factors, contagion, or heredity is not known. Observation of the whole family is strongly recommended.

Children who have had rheumatic infection usually have more than one attack, and each attack increases the probability of heart damage. There is no method known for the specific prevention either of the initial infection or of the resultant damage. The aim, therefore, must be to keep the child in good general health, free from exposure to childhood infections and colds, both at home and at school.

For many years these children have to be kept under medical observation at intervals varying from weekly visits to semiannual and annual visits. One purpose of this long-time observation is to ascertain the amount of physical exertion the child is capable of enduring and as far as possible to protect the damaged heart from being subjected to undue strain. Another purpose is to detect early signs of reactivation of the infection, such as pallor, loss of appetite and weight, low-grade fever, mild joint pains, and nose bleeds, pain, and palpitation.

How can this be accomplished without making the child so conscious of himself and his illness that he becomes self-centered or neurotic or uses his illness to gain attention or other satisfactions? How can guidance and discipline be maintained by unintelligent, indifferent, or overanxious parents without injury to the child? How can the child be given adequate diet in a home of scarcity, without creating feelings of deprivation and envy among his sisters and brothers who also need and would enjoy fruit, vegetables, eggs, and milk? How is limited activity to become a reality when families live in hilly country or in sparsely settled rural areas where climbing or walking long distances is a part of daily living? These are some of the medical social problems to be met for patients with rheumatic heart disease.

The need for totally or even partially restricted activity makes transportation a matter of major importance. Rarely have communities made adequate provision for transportation, so that clinic, hospital, and school attendance can be readily available to large numbers of children in urban and particularly in rural areas. Too much reliance has frequently been placed on the helpfulness of friends or neighbors. They sometimes will assist but often and for many reasons they cannot be counted on for regular and frequent service. The lack of access to medical resources makes them as unattainable as if they actually did not exist.

Extended absence will inevitably retard the child's progress in school. This places him under the strain of attempting to maintain himself in an unequal situation with his classmates. If he falls behind his class, he is under the stress of feeling inadequate among younger children. He may give up the struggle entirely then by leaving school. This will only increase his insecurity, as his lack of education will further restrict the limited vocational possibilities for persons with heart defects.

Guidance in the type of vocational activity suitable for each child is essential in a program directed toward the conservation of health and the promotion of child welfare. The broadening of vocational opportunities for all types of handicapped persons is still an undischarged responsibility of many communities.

As the State programs develop services for children with rheumatic fever and rheumatic heart disease, other social problems will arise, influenced or created by the geographic location, the topography of the country, or the lack of essential community resources. Thus, local circumstances will produce various and differing needs, but one of the essentials common to all programs, wherever they exist, will be a real continuity of medical, social, and nursing services.

• CHILDREN IN A DEMOCRACY •

Following up the White House Conference on Children in a Democracy[1]

By H. Ida Curry

Acting Director, National Citizens Committee, New York

What is happening to the children of America as a result of the deliberations of the White House Conference on Children in a Democracy which held its last session a year ago?

This fourth White House Conference was not content merely to state conclusions as to various factors conditioning child life in America. In order to be sure that America's children would benefit by its deliberations, the Conference provided for the establishment of a nongovernmental National Citizens Committee to stimulate a follow-up of the Conference recommendations in all parts of the country. It also recommended an interagency committee which would bring together representatives of the Federal agencies to cooperate in this undertaking, and these two committees have been earnest in prosecuting the work entrusted to them by the Conference.

The National Citizens Committee has undertaken to stimulate the interest of some group in each State to study the recommendations of the Conference in relation to situations surrounding its own children, discover what needs to be done for the protection and advancement of the children, and initiate measures which will be of benefit to them.

In 20 States programs are under way or about to begin, and in addition more than 20 national organizations have taken steps looking toward active participation of their members in following up the Conference recommendations. All the State follow-up organizations represent a coordinated interest of government agencies and citizen groups. The selection of chairmen by the first 14 State groups illustrates the breadth of interest: 3 are from public-welfare departments, 1 is from a public-health department, 2 are from the educational field, 1 is a State senator, 3 are professional men, 1 is a business man, and 3 are leaders in citizen organizations.

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[1] *See also* The Follow-up Program of the White House Conference on Children in a Democracy, supplement to *The Child*, Vol. 5, No. 1 (July 1940).

As State follow-up programs were contemplated many questions concerning organization and program arose. The National Citizens Committee contributes the following as fundamental considerations or principles upon which decisions should rest.

ORGANIZATION

The recommendations of the White House Conference on Children in a Democracy in regard to follow-up programs, adopted at its closing session January 20, 1940, should be studied carefully. Any work which is to use the name of the White House Conference should be in general conformity with their intent although the situation in each State necessarily will determine the most practicable procedure, form of organization, and program.

Immediate objectives for State programs.—As the recommendations of the White House Conference involve Federal, State, and local participation and action, it is desirable that the agencies and individuals best equipped to do so should review jointly the recommendations in relation to the present situation within the State with respect to child life, particularly in the fields of health, education, and welfare, to determine what is now being done in behalf of children; the interrelationship of present activities in the various fields; the adequacy of existing legislation and administration; and the extent to which all children who need help are benefiting by present provisions for each type of service. In this way the group can determine what needs to be done to bring to the children of the State the essentials which, in the opinion of the Conference, a democracy owes to its children.

How to start.—Some one person has to take the first step. As the White House Conference was not a delegate body, there is no chairman of such a group to initiate a State follow-up organization. State situations and recognized leaderships will probably determine the person to take the initiative. Usually some one or two of those who attended the Conference draw together a few others most deeply interested to act as a steering committee which, with the objectives clearly in mind, will consider questions such as the following:

> Is there a State-wide agency of suitable character to undertake a follow-up program which shall include a coverage of subject matter as well as of geographic territory?
>
> If a new organization is necessary, what should be the composition of the group in relation to the variety of subjects to be reviewed and the territory to be covered and in relation to present government and citizen interests and influences?
>
> How and by whom is a group to be authorized—shall it be a self-constituted voluntary group, possibly the White House Conference group adding to their number, or a quasi-official group by designation of the governor?
>
> What types of immediate and long-range activity should be undertaken in consideration of the extent to which movements are already under way in the various fields? How can these activities be coordinated and strengthened, and—of great importance—what attitude shall the organization take in relation to legislative or other official processes?
>
> Will a citizens' organization, an organization of officials, or one comprising both within its membership be most likely to obtain the desired results?

The State planning committee, by giving thought to such questions, will be able to present a definite plan with specific recommendations as to the membership of the proposed organization and its program, either when asking the governor to act or when presenting the subject to a larger group called together to discuss the matter or to perfect an organization.

IS A STATE FOLLOW-UP ORGANIZATION NECESSARY?

One question that came to the National Citizens Committee was whether a State follow-up committee is essential in view of the spontaneous interest shown by a large number of organizations, including the National Congress of Parents and Teachers, the General Federation of Women's Clubs, departments of the State government, and many other agencies—public and private. Some form of machinery is necessary to harmonize and bring together the forces of the State or locality in which action is desired: To coordinate the activities of such agencies; to pool their findings; to give due consideration to movements already under way; to arrive at an agreement as to what is of greatest immediate importance; to adopt a definite, practical plan of action; and to determine the part each agency is to play in securing results.

If the desired ends can be achieved without a new organization, so much the better, but confusion would certainly result if each separate organization should select a project of particular interest to itself and then attempt by its own means to obtain backing for it with no consideration of other measures which conceivably might be of far greater benefit to many more children.

State follow-up committees or agencies will do well to utilize to the utmost the leadership and interest of citizen groups whose combined efforts, if directed to any given proposition of immediate importance, could create a background of public opinion assuring favorable consideration to questions of legislation, finance, administrative practice, or any other matter affecting the well-being of children.

STATE AND LOCAL INTERESTS

Another question that has arisen is the practicability of separate city follow-up committees. Several considerations should not be overlooked in seeking an answer to this difficult question, among them the following:

> State laws providing for education, health, and welfare, at least in all major aspects, are equally applicable to the whole State, including cities. No modification of State laws should be advocated without due consideration of the effect the change will have in all parts of the State and in various types of communities.
>
> City-charter provisions of purely local application may best be studied locally, but in such studies their relation to the State statutes should not be overlooked.
>
> A subcommittee studying the application of the recommendations of the White House Conference to the situation of a local community generally should report back to the State group before determining action on any matter involving State law, State appropriations, or State administration. Independent action, without centralized consideration, might lead to conflicting conclusions and opposing lines of action being advocated by State and local groups.
>
> It is probable that State and local conditions will gain more through their consideration by a group in which both rural and urban areas are represented than through separate consideration of the problems of city, village, and rural area by groups selected on a residential basis.

PROGRAM

The recommendations of the White House Conference were considered practical and capable of being carried out within a reasonable period of years, but it is essential for a State follow-up agency, in conference with public and voluntary agencies, to select objectives which will be of greatest relative benefit to children and which it is practicable to undertake at once. State follow-up organizations will probably have the task of coordinating the programs of various groups or individuals wishing to push special bits of reform and of leading them to broaden their views and consider their specialized interests in relation to the whole program; also of suggesting parts of the follow-up work appropriate for such agencies to sponsor.

The relative value of direct and indirect action by the State follow-up agency needs careful consideration. Should it undertake a particular project by and of itself, or should its function be to stir up interest and leadership among other existing agencies?

Among other activities, the State follow-up agency may find it desirable to instigate or conduct field studies; to initiate or lend its influence to various new projects; to sponsor needed legislation, or to oppose undesirable legislative proposals; to arouse a demand for modification or improvement of administrative practices; to induce the adoption of more satisfactory qualification requirements for personnel in government or in voluntary agencies; or to influence a more adequate financing of the government and voluntary agencies.

In expanding industrial centers and in neighborhoods near military posts, children already are being affected by limitation of housing, sanitary, educational, health, and leisure-time facilities, and by lack of social services to protect them from neglect, abuse, or exploitation. It is important that the dangers to children growing out of these national-defense developments be promptly recognized and dealt with. Therefore, follow-up agencies should not fail to consult with State and local defense councils in regard to these problems.

FOLLOW-UP COMMITTEES

Fourteen States had definite follow-up programs by the middle of December, and it is probable that at an early date five more States will be added to the list:

Arkansas
Delaware
Florida
Indiana
Louisiana
Massachusetts
Michigan
Nebraska
Nevada
New Jersey
North Carolina
Texas
Vermont
Washington

Committees are also at work in Cleveland, Ohio, Providence, R. I., and Pima County (Tucson), Ariz.

In half a dozen other States preliminary work has been done, and dates have been set for the organization of State follow-up committees.

Report of the White House Conference as It Relates to the Delinquency Field[1]

BY ALICE SCOTT NUTT

Acting Director, Child Guidance Division, U. S. Children's Bureau

The White House Conference of 1940 is the fourth decennial conference by which the people of the United States have sought to promote the welfare of the Nation's children. The theme of the 1940 conference is indicated by its title, Children in a Democracy, especially appropriate at this time, and by the two points which the President of the United States asked it to consider:

> First, how a democracy can best serve its children; and, the corollary, how children can best be helped to grow into the kind of citizens who will know how to preserve and perfect our democracy.

As a basis for its deliberations the Conference reviewed available data to discover the extent to which the 36,000,000 children under the age of 16 in the United States were being cared for by their families and community services; the problems created by the depression years; and the practices and conditions prevailing before that period that still produce grave social problems.

These data show that in 1939 at least 8,000,000 children were receiving economic assistance in their own homes, including more than 700,000 benefiting from aid to dependent children under the social-security program, and that many additional children were in need of assistance but were not receiving it; that other children, 250,000 according to the last Federal census of children in foster care, were being cared for in institutions or in foster-family homes; and that, although the exact numbers could not be accurately estimated, large numbers of children were suffering from physical and mental defects or handicaps.

Of particular interest for this paper are those receiving or needing treatment by reason of problems of behavior or delinquency. On June 30, 1939, at least 28,000 children were resident in State training schools for delinquent children. On the basis of statistics reported to the Children's Bureau by children's courts it was estimated that approximately 200,000 children come to the attention of these courts each year because of delinquency. These data show the existence of numerous and varied children's problems. With the increasing development of resources for child-welfare services, the actual extent of need for social services, for protection and care of children handicapped by social, mental, or physical disabilities, and for prevention of maladjustment is becoming more evident.

The Conference recognized that, because primary responsibility for the care of children in a democracy centers in the family, the needs of the great majority of children must be met by their families. The families meet these needs directly, or indirectly by providing community services either in the discharge of their responsibility as citizens or through their participation in the maintenance of privately supported activities. Care and protection for the children who have no parents or natural guardians, or whose home conditions or individual disabilities are such as to require special consideration, must be afforded through services furnished by the State or local government or private agencies.

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[1] Speech given before Delinquency Section of the New York State Conference on Social Work, New York, Oct. 10, 1940.

The essentials of a community program of social services for children as outlined by the White House Conference of 1940 have direct implications for work in the field of preventing and treating delinquency. In brief, they are:

> (1) A comprehensive program of social services to children whose home conditions or individual difficulties or disabilities require special attention should be provided in every county or other appropriate area; and (2) the local public-welfare department should be able to provide all essential social services to children, either directly or through utilizing the resources of other agencies.

These statements emphasize three essentials of a modern program of social services for children:

> (1) Local social services available to the child in his own home and community (not only in some more or less remote agency or institution); (2) services available for all children in need, including services suited to the child's needs; and (3) public responsibility for the provision of such services.

Probably there is not one of the sections of the 1940 Conference report whose findings would not have some implication for the delinquency field. Of specific pertinence to the subject of this paper are the discussions with regard to the children's court, institutional care of delinquent children, and community measures for the prevention and treatment of juvenile delinquency.[2]

As discussion turned to the children's court the fact was deplored that in some communities hearings in children's cases are held in juvenile courts conducted along the lines of police courts or in criminal courts; that some children's court judges lack the necessary qualifications for dealing with the legal and social problems involved in children's cases; and that in some communities probation staffs are inadequate and are not qualified for their work. It was emphasized that social service is essential in connection with court action and that successful administration of the court depends primarily upon the qualifications and personality of the judge and upon his assistance by qualified social workers. The judge, it was believed, should have adequate legal training, but above all he should have understanding of children and knowledge of social conditions and community services. It was thought that in the larger communities the court should have its own probation staff of trained social workers but that in less populous areas it might use the services of child-welfare workers in the public-welfare department.

In view of the many and divergent points of view, which have found expression during recent years, as to the place and function of the children's court it was to be expected that the Conference meetings would have similar discussion. Review of the General Report of the White House Conference and careful consideration of the statement on social services indicate that participants in the Conference recognized the importance of the role played by the court in the exercise of its judicial function and sought to improve and safeguard this function. They did not advocate the extensive use of the services of the court for unofficial or informal cases or the expansion of its activities to include those primarily devoted to the prevention of delinquency.

Agreement was reached that the function of the children's court is to provide legal action based on social study in cases of delinquency requiring court action. There was general agreement that the court should be relieved of responsibility for services to children whose problems do not require legal adjudication and that such services should be supplied by local social agencies. In the development of public social services for children, now established in about 500 counties, evidence is found of splendid cooperation between courts and agencies and of increasingly extensive use of the social services of the agencies.

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[2] Copies of Preliminary Statements submitted to and the General Report adopted by the White House Conference on Children in a Democracy are available upon application to the Children's Bureau, U. S. Department of Labor, Washington, D. C.

The points of view expressed do not necessarily indicate ebbing confidence or interest in the children's court. They do indicate need for better understanding of the types of cases in which the services of the children's court are essential—arrived at through definition of the role of the court in the child-welfare program. They indicate also appreciation of the significance of the judicial function of the court and unwillingness to draw upon the limited social services usually available in courts for cases that do not require a judicial action and which other public or private agencies can serve. Finally, they indicate the growing realization that the authoritarian character of the court places certain limitations upon its treatment services not experienced by nonauthoritarian agencies.

In the more detailed report on social services for children institutional treatment of delinquent children is dealt with as one of the types of special care which has been provided throughout most of the United States on a State rather than on a local basis. As in the case of the children's court, the Conference considered the function of the institution in the total child-welfare program and the types of problems with which it should deal. Institutions intended for the training of delinquent children have often had to care for children, especially those from rural communities, who have not had the benefit of skilled assistance from a social worker or a child-guidance clinic in working out their problems in their home communities. In realization of this it was agreed that training schools should not be used as "catch-alls" for problems which should be dealt with in the community by a children's agency or by courts adequately equipped for social-service work.

Discussion with respect to the program of the training school took cognizance of the fact that the institutional experience is an interlude in the child's life; he comes from the community to the institution and goes back to the community again. While a boy or girl is under care, the training school must provide the opportunities normally extended by the family, the school, and the community agencies which contribute to the health and education of children and to the formation of their character. Because the institution is a part of community life, the activities of the training school in the social, educational, religious, health, and recreational fields should be closely related to the activities of other community agencies in the same fields. Furthermore, the children in training schools usually present a greater number of educational problems, and more serious ones, than are found in the usual population of the public schools. Provision for academic and vocational training, therefore, should meet at least the standards set by the State for public schools and should be adapted to boys and girls in special need of social adjustment and vocational guidance. The values of both individualized service and group experience should be incorporated in the institutional program.

To carry on such a program and to attain such goals the training schools must have equipment equaling the resources of a good community. These include buildings and equipment providing comfortable and attractive living and sleeping quarters; adequate diets adapted to the needs of growing children; and opportunities for health supervision, medical care, and psychiatric service provided by the institution or available in the community. Essential also are adequate space and equipment for educational, vocational, and recreational programs designed to meet the needs of children as individuals and as a group.

One of the points brought out was that the development of small, specialized institutions with provision for transfer of children from one to another of these is preferable to the development of large institutions. This was based upon the realization that the same institution cannot serve adequately the needs of both young children and older youth nor provide treatment to both mentally deficient and mentally normal children, as many State training schools for delinquents are now being asked to do.

In connection with the cost of institutional care it was pointed out that inevitably the per capita cost of care by institutions will rise as States and localities plan for a more adequate and effective program for the care of children with personality and social problems. The public, therefore, must be helped to think of costs in terms of the entire program of the State and local community for the prevention and treatment of delinquency and to recognize the economy of preventive work and highly efficient, selective service to those most in need.

Emphasis was placed on the fact that the staff of the institution is of far greater importance than physical equipment. Institution personnel, therefore, should include cottage masters and matrons prepared by education and experience to provide sympathetic understanding and wise guidance; teachers, social workers, recreational leaders, religious advisers, and other professional personnel whose qualifications are of high character; and executive and advisory staff able to give effective leadership in the administration of the school and its community relationships.

Cognizance was taken of the conclusions which are being reached by persons in the training-school field, or closely associated with it, in regard to the relationship that should exist between these institutions and the social agencies in the communities from which children are received. These conclusions have been reached as the result of consideration of the methods and problems faced by the training schools. It was stated:

> Training schools for juvenile delinquents should receive only such boys and girls as need the special treatment afforded by such institutions, and their work should be closely related to social-service activities in the communities from which children are admitted.

Recognition was given to the greater emphasis being placed upon the need for constructive case work in the community, including work with the child after his discharge. It is becoming increasingly evident that in most instances immediate responsibility for case-work service for the child and his family and assistance to the child after his release from the institution will be carried by a child-welfare worker in the community. Under such circumstances institutions need social workers to serve as consultants or liaison officers between the institution and the children's communities.

The relationships that should exist between State institutional care of children and other State and local services to children were not overlooked. It was pointed out that the introduction of child-welfare services in local communities under State leadership, as well as increased resources within the State welfare department for community service, have had during recent years a marked effect in reshaping policies of State care of children. In some States child-welfare-service funds have been used to make studies of institution populations and of methods of intake and discharge in relation to the social services in the communities from which the children were committed. Already these studies, which were undertaken to determine the extent to which children in State institutions are there without real cause, and the greater availability of local services are affecting the volume and kind of care provided by the State for children for whom it assumes direct responsibility. Developments of this sort indicate the desirability of viewing the institution as one unit in the total program of State child-welfare services.

The reports do not confine attention to the traditional agencies for dealing with juvenile delinquency—the court and the institution. In keeping with the growing interest of the public generally, much thought was given to the community's responsibility for preventive measures and treatment services.

It was recognized that juvenile delinquency in large measure reflects detrimental conditions in the community. Break-down of family life is a potent causal factor. Much delinquent conduct that comes to the attention of the police and the courts could be prevented if necessary safeguards were provided for children whose homes lack the essentials for proper care and protection. Inflexible school programs, with resulting educational maladjustment, often lead to serious personal and social maladjustment evidenced by truancy and other types of unacceptable behavior. Many communities make little provision for the recreational activities needed especially by boys and girls whose homes and environments do not afford normal outlets for their interests and need of companionship.

It was emphasized that prevention and intelligent treatment of delinquency call for knowledge of personal and environmental conditions that may have a bearing upon the delinquent behavior of the individual child. Social and economic factors contributing to maladjustment must be understood and dealt with, as well as the physical, mental, and emotional characteristics of the child. Prevention and treatment of juvenile delinquency are, therefore, not problems for juvenile courts, child-guidance clinics, and training schools alone. They are also the vital concern of the church and the school; of child-welfare, family-relief and service, and public-health agencies; and of organizations providing recreational and group-work service for children and youth.

The conservation and upholding of normal home life are preventive measures of primary importance. Social services, which are society's means of endeavoring to meet the needs of children whose well-being cannot be assured by their families or by the community—services that should be available to all children—have a double function:

> (1) Helping to provide material resources and other environmental conditions favorable to the physical, mental, and social development of children, and (2) aiding individual children to find personal security, acceptable means of self-expression, and satisfying achievement within the cirumstances under which they live.

Schools and social agencies have become increasingly aware that child-guidance clinics or other psychiatric services are necessary to the understanding and treatment of conduct problems. It is encouraging that, although these services have in the past been limited mainly to the larger cities, experimentation now under way is discovering practicable methods of making psychiatric service available to children in small cities and rural communities. Adequate play facilities, carefully supervised group activities, and constructive companionships and associations for children in neighborhoods where they reside all contribute to the prevention of delinquency. Children who do not readily enter into existing activities should have specialized services to meet their needs.

Throughout, the White House Conference stressed the interrelationship of problems of behavior and delinquency with other types of children's problems, with family problems, and with still broader problems of our social and economic life. It emphasized the need for sound basic services and for comprehensive programs of child welfare which take into account the needs of all children. Finally, the fundamental thesis of the Conference report in relation to delinquency is found in these words:

> Measures aimed at basic causes are required if conditions in the home and community contributing to delinquency are to be removed. Youthful energies must be directed into useful channels.

• ADVISORY COMMITTEE RECOMMENDATIONS •

Report and Recommendations of Advisory Committee on Maternal and Child Health Services

December 2 and 3, 1940

The following reports were submitted to the Children's Bureau Advisory Committee on Maternal and Child Health Services by the subcommittees on child health and maternal health and, after discussion, were adopted unanimously on December 3 by the full committee:

REPORT OF THE SUBCOMMITTEE ON CHILD HEALTH

The national-defense program has caused a rapid increase in population in villages, towns, and cities adjacent to military cantonments and in those with rapidly expanding defense industries. Such expansion of population brings with it urgent problems of health protection for the whole populace, but especially for children and pregnant women in the families of workers and enlisted men.

The committee recognizes that these concentrations of population have come about for purposes related to the whole of the population of the United States, not merely the areas in which they occur. The problems arising from them are the concern of the whole of the United States, and the failure to meet them is a potential adverse influence upon the whole country.

In view of this emergency the Advisory Subcommittee on Child Health of the Children's Bureau has given careful consideration to the urgency of providing facilities to meet existing conditions—bad housing, crowding of households, inadequate provision for recreation, bad sanitary facilities, inadequate control of communicable diseases, and lack of health supervision and medical care for mothers and children.

The committee recognizes the progress that has been made under the maternal and child-health program in establishing State and local services for mothers and children. There must be no interruption in the development of this long-range program. The committee is also cognizant of the fact that large gaps in this program still exist which must be closed if anything approaching an adequate program is to be put into effect.

Because of the greatly intensified and additional problems created by national defense, however, the need for immediate expansion of these services is even more urgent than was previously apparent. The experience gained in the last few years has made it possible to outline clearly the ways in which this emergency may be met. Two obstacles present themselves, however: lack of funds and deficiency of trained personnel.

The Advisory Subcommittee on Child Health *therefore recommends:*

1. That increased resources be made available to the Children's Bureau to enable it—

(*a*) To hasten the development of an adequate maternal and child-health program commensurate with existing needs for health services and medical care through substantially increased grants-in-aid to States under title V of the Social Security Act;

(*b*) To make careful investigations of the health, medical, housing, and recreation facilities available to wives and children of workers living in or near the defense-industry areas and of enlisted men in communities near military cantonments, and to provide facilities and services to meet the health and medical needs as they are found to exist; and

(*c*) To plan for the protection of mothers and children in any other emergency situation arising from national defense. We refer here to the immediate making of appropriate plans for the protection of mothers and children in areas of military danger and for their evacuation and placement in selected reception areas.

2. That, in view of the known insufficiency of personnel for the care of mothers and children, the Selective Service Board, the local draft boards, and the military services be urgently requested, in calling physicians for military duty, to give as much consideration as possible to retaining in the local communities those physicians who are responsible, in the fields of public health and medical practice, for maternal and child care.

The Advisory Subcommittee on Child Health *further recommends:*

1. That, in view of the necessity for recognition by the National Defense Council of the needs of mothers and children in the civilian population, the Children's Bureau be given representation in the Health and Medical Committee of the National Defense Council;

2. That the resolution of the American Academy of Pediatrics calling for the appointment of a pediatrician to the Health and Medical Committee be endorsed; and

3. That the chairman of the Advisory Committee on Maternal and Child Health Services transmit these recommendations to the Secretary of Labor and seek an appointment with the President of the United States to lay before him the recommendations of the committee and to discuss the urgent need to safeguard the health and welfare of mothers and children as part of the national-defense program.

Report of the Subcommittee on Maternal Health

The committee recognizes that the great improvement in maternal and infant care which has resulted from the leadership and efforts of the medical profession are not uniform throughout the country. It is our belief that in many areas of the United States, especially where maternal and infant death rates are highest, there is urgent need for providing medical and hospital care for maternity patients and newborn infants who cannot now obtain this care. New and urgent situations have been and are being created by the concentration of families in areas where defense programs are being developed. Plans must be made immediately to provide the mothers and children in these areas with needed health services.

It is recognized that the need for better maternal and child care is intimately connected with other economic and medical deficiencies and that a truly effective program must have broad objectives and must be developed in cooperation with other governmental agencies.

In the opinion of the committee the problem of medical and hospital care for mothers and infants in many of the areas of greatest need would be solved by extending the use of existing facilities and by constructing and maintaining new hospitals where needed for the care of maternity patients and newborn infants with adequate safeguards to protect the quality of service in these institutions.

The committee recommends that additional funds be appropriated under title V of the Social Security Act to assist the State and local health agencies in meeting the health needs of mothers and children, both by extending the use of existing facilities and by establishing and maintaining hospitals for the care of mothers and newborn infants where needed.

Since the evacuation of mothers and infants from densely populated areas is an ultimate possibility, it is *further recommended* that plans be considered for transporting such persons to safe areas and for providing the medical and hospital services which may be needed.

Report of the Advisory Committee on Community Child Welfare Services

December 2, 1940

In making the following recommendations the committee desires to emphasize the fact that the Federal Children's Bureau came into existence as a Federal Government response to requests from localities in all parts of the Nation, based on the concern of people in such localities for the well-being of their children.

The committee highly commends the Bureau for its consistent policy of a fine regard for local initiative, enterprise, judgment, and responsibility, and the members of the committee are unanimous in strongly urging continuing adherence to that policy in the further and extended work of the Bureau in research, community education, and particularly in the sharing in direction and operation of direct services to children in places and times of special need.

In brief, in making specific recommendations, the committee assumes that in the further development of child-welfare services under the provisions of the Social Security Act the underlying policy will be that of joint participation of local, State, and Federal enterprise.

After consideration of the report of the Child Welfare Division of the Children's Bureau on developments in child-welfare services under the Social Security Act and evidences of urgent needs growing out of the defense program, the committee was unanimous in making the following recommendations:

1. That increased Federal funds should be made available under title V, part 3, of the Social Security Act, for the following purposes:

(*a*) To provide Federal funds, on the basis of joint Federal and State planning, for paying part of the cost of local child-welfare services in rural political subdivisions and in other areas of special need, in order that the continuation and progressive development of such services will be assured;

(*b*) To provide child-welfare services which are sorely needed in many communities affected by the defense program;

(*c*) To enable the Federal Government more fully to participate financially, on the basis of joint planning, in the development of the States' responsibilities for stimulation and leadership in child-welfare programs;

(*d*) To enable the Federal Government more fully to participate financially, through both demonstrations and continuing support, when needed, in providing certain types of services, such as case work or child guidance, which are essential in an adequate program of care of children, as for example, public institutional care for delinquent children.

(*e*) To make available increased Federal funds on the basis of joint planning, for improving the quality of personnel for child-welfare services, through provision for study in educational institutions and other measures.

(*f*) To provide further Federal financial participation in special projects undertaken by State agencies which involve demonstrations or studies in the fields of community planning, child guidance, services to children of minority and other disadvantaged groups, and the development of community resources for the prevention of juvenile delinquency.

2. That the Children's Bureau should be provided with resources to plan with the State agencies to meet special needs of children and youth for protection and guidance, growing out of the defense program.

3. Many problems of social welfare are arising in communities adjacent to defense industries and training camps. These include dangerously inadequate accommodations for housing, schools, health, recreation, and religious services. Total defense requires that these social problems be carefully planned for. This committee recommends that definite coordinated planning for social needs be undertaken as part of the defense program, and further, that the interests of children and youth should be represented through the Children's Bureau, in such coordinated national planning for civilian defense, and through appropriate agencies in regional, State, and local planning for civilian defense.

The Children's Bureau Register of European Children

By Harold R. Hosea

Supervisor, Register of European Children, U. S. Children's Bureau[1]

During the period June to November 1940 well over 5,000 European children arrived in the United States to seek refuge from the war. The necessity for a single, accessible record on these children was recognized early in the summer, and it seemed desirable for the Children's Bureau to undertake the compilation of the essential information.

The need for current data on the children is of three general types. In the first place, State and local agencies charged with the responsibility for enforcement of statutory requirements governing foster-home care were, in general, without access to any systematic and authoritative source of information on the numbers, identity, characteristics, geographic distribution, and arrangements for foster care of the children. The Children's Bureau, with the assistance of the United States Committee for the Care of European Children, is, therefore, cooperating with State departments of welfare and health by furnishing this information as required. As might be expected in connection with a large-scale migration of this sort, a few cases of financial difficulties and adjustment problems have arisen. Official data not otherwise available immediately are frequently required by local agencies assisting in such cases and are supplied by the Bureau.

A second function of the register concerns the need for basic statistical data for which numerous requests have already been received.

Finally, relatives, friends, and occasionally parents, anxious to get in touch with individual children, have sometimes lost contact with them in the confusion of the emergency conditions under which some of them left Europe. Such information is supplied for this purpose in response to requests from individuals and organizations. It should be pointed out, however, that lists of children's names and addresses are not, as a matter of policy, furnished except to a Federal or State agency.

A brief outline of the operation of the register will serve to illustrate the types of information collected and the functions performed. Basic, of course, is the definition of the groups of children recorded, which may be summarized as follows: Any child under the age of 16 years whose birthplace or place of last permanent residence is in a European country, who has entered the United States since September 1, 1938, and who (a) is to join a person other than a parent already in this country or (b) is not accompanied by both parents. The recording of children accompanied by a parent or relative might seem, at first glance, to be unnecessary. Such cases constitute almost half of the total registered. It has been found, however, that, where financial or other adjustment problems arise, they are most frequently those of children accompanied by mothers. This may well be a result of the greater general interest in unaccompanied children and the provisions set up for their care.

The original source of information on each child is the manifest on file in the office of the United States Immigration and Naturalization Service at the United States port of entry. The data shown on manifests are adequate to permit selection of records on the basis of the foregoing definition. The child's name, basic identifying detail, and data on immigration are transcribed by special clerks assigned to this task at Ellis Island, N. Y., and St. Albans, Vt., the two immigration districts through which most of the children enter. In other areas data have been furnished by Immigration Service district directors.

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[1] The address of the Register of European Children is 215 Fourth Ave., New York.

A simple questionnaire on each child is sent to the person reported by the child as the individual whom he plans to join. This questionnaire provides data on addresses and school arrangements and forms the basis for the current record. This information is furnished automatically to State departments of health and welfare as required.

There are, of course, a number of other agencies both public and private in which current information on European children is maintained. In most cases, however, one or both of two circumstances have made it impracticable for any of these agencies to perform the functions of the Children's Bureau register.

In the case of records maintained by private agencies the principal difficulty results from the fact that a private agency is concerned only with a particular group of children. The United States Committee for the Care of European Children may be mentioned as an example. The records of this committee are, quite properly, limited to children who have been evacuated from Europe under its auspices and whose support has been guaranteed by its corporate affidavits. Since the committee has, in general, restricted its activities to children who come to the United States unaccompanied by relatives, its records are limited on the same basis. This committee does, however, maintain detailed records on the more than 800 children under its care; the Children's Bureau register does not duplicate these records. In the case of this organization, the cooperation is particularly close because of the scope of the committee in arranging for the evacuation of children from Europe. The Children's Bureau register is located in the New York offices of this committee, which shares in the financial support of this activity. Clearance with other organizations maintaining records on special groups is undertaken.

The Immigration and Naturalization Service and the Alien Registration Division, both within the United States Department of Justice, have information on all the children. Their records are, however, restricted to data required for the enforcement of statutes for which the Department is responsible, and their records are of a sort different from those required by the Children's Bureau register. Arrangements for the interchange of information with these agencies are in effect.

The 5,000 European children who have thus far arrived to avoid the hazards of war are now scattered throughout 46 States and the District of Columbia. It is planned to tabulate certain of the data on the children and to maintain current records so long as substantial numbers remain here. It appears likely that such records will become increasingly important, especially in view of the uncertainties of the situation abroad with the attendant difficulties in communication.

• BOOK NOTES •

Juvenile Delinquents Grown Up, by Sheldon and Eleanor Glueck. Commonwealth Fund, New York, 1940. 330 pp. $2.50.

Coming as a sequel to One Thousand Juvenile Delinquents, published in 1934, this volume is significant in that it completes the first study in which a large group of delinquents has been followed for as long as 15 years. One Thousand Juvenile Delinquents dealt with the study of 1,000 delinquent boys during the first 5-year period after completion of a period of treatment by the Boston Juvenile Court and the Judge Baker Foundation, now known as the Judge Baker Guidance Center. In Juvenile Delinquents Grown Up the careers of the same boys are followed through the next 10 years of their lives.

Junior Placement; a survey of junior-placement offices in public employment centers and in public-school systems of the United States, by Jane H. Palmer. Children's Bureau Publication No. 256. Washington, 1940. 131 pp.

In answer to a questionnaire distributed on a Nation-wide basis in February 1937, full-time junior-placement offices were reported by 21 public-school systems and 52 public employment offices. Two-thirds of these 73 offices were in metropolitan areas of 100,000 or more population. The survey was made in a period of rapid expansion in special placement programs for juniors within the public-employment-office system. An appendix to the report points out that in October 1939, according to a questionnaire survey made by the Employment Service Division of the Bureau of Employment Security (formerly the United States Employment Service), there were 177 cities in which public employment offices had on their staffs counselors giving full time to work with junior applicants, of which 166 had a population of 10,000 or more.

The major part of the findings of the Children's Bureau report is concerned with the specialized techniques of junior-placement work as they had been developed in 12 offices visited in the fall and winter of 1937 and early 1938, following the questionnaire survey.

An important feature of junior-placement procedure was found to be the interview between applicant and counselor which initiates the process of registration with the placement office. This interview, which is conducted with as much privacy as possible, includes a discussion of the applicant's school experience, previous jobs and interests, the kinds of work available in the community for which the applicant may be qualified, his health, and even his hobbies.

The report points out that the counselors often find it advisable to verify and supplement some of the basic information obtained from the applicant through the use of personal-interest blanks, psychological and other types of tests, school records, references from employers, and health records.

In most of the offices visited, junior-placement counselors not only handle the registration and counseling of young applicants but also refer applicants to employers requesting the services of the placement office. Almost all counselors spend a scheduled proportion of their time in soliciting suitable job openings and in revisiting employers in order to maintain cooperative relationships.

YOUNG WORKERS AND THEIR JOBS IN 1936; a survey in six States, by Helen Wood. Children's Bureau Publication No. 249. Washington, 1940. 95 pp.

Interviews with 450 working children under 16 years of age and 1,569 of 16 and 17 years in urban communities in six States form the basis of this study, which was undertaken in 1936 in order to make available information on the kinds of work open to young persons, the conditions of their work, and the relation of their employment to unemployment among adults. The States in which the children lived were Massachusetts, New Hampshire, Indiana, Missouri, Alabama, and Georgia.

The resultant picture of boys and girls entering the ranks of wage earners without adequate education or vocational preparation, and engaging for the most part in poorly paid jobs that nevertheless exact heavy physical toll, indicates the need for an increasing public awareness of the industrial and social problems involved in the employment of young workers.

These boys and girls had all left regular day school and had been employed, within the month previous to the interview, in industrial, commercial, and service occupations (exclusive of agriculture, domestic service, and street trades).

The findings of this study, made before the enactment of the Fair Labor Standards Act of 1938, point clearly to the fact that much employment of young workers, even in urban communities, is in trade and service businesses of a local character outside the coverage of the act. Working conditions surrounding such employment were in 1936 far below the wage, hour, and child-labor standards set by Congress for employment covered by the Fair Labor Standards Act.

SOME ASPECTS OF SOCIAL CASEWORK IN A MEDICAL SETTING; a study in the field of medical social work. Prepared by Harriett M. Bartlett for the Committee on Functions, American Association of Medical Social Workers, 1940. 270 pp.

Because of its clear analysis of the social problems associated with illness and its sympathetic discussion of the meaning of illness to the individual who is sick, this book greatly enriches the literature in the field of medical social work. The central theme is that the primary concern of the medical social worker and others in the "medical setting" is service to the patient.

The book is based on the third of a series of projects carried out by the American Association of Medical Social Workers in the study of the function of medical social workers. The first was an extensive study of case practice in this field; and the second was an intensive study of a smaller group of medical social cases. The present project is a "study of social case work in a medical setting, stressing the briefer types of case work and shorter contacts which are so frequent in this type of work." This study was begun in 1935 and was carried on for 3 years. The report is based on the analysis of several hundred case summaries and on fully recorded case narratives or interviews submitted by more than 100 medical social workers from 38 hospitals in various parts of this country and Canada.

The book is divided into seven chapters devoted to the presentation and analysis of case material and to the discussion of various factors that influence the practice of case work in a medical setting. In the first of the seven chapters there is a discussion of recent changes and current trends in social case work and of the importance of the increasing emphasis being placed on psychosomatic medicine by leading clinicians and medical teachers. Chapter 2 is devoted to case illustrations and discussion, and further case material is effectively used throughout the report to show the unique characteristic of medical social work in a variety of activities, some of them administrative, carried on in the medical setting by the medical social workers.

Miss Bartlett has shown graphically and clearly what illness may mean to the patients and the part that medical social work plays in improving the service they receive. The book will be of use not only to social workers but to doctors, nurses, hospital administrators, and others who have the welfare of the sick person at heart.

The Seventh National Conference on Labor Legislation

The importance of maintaining labor standards and of making further gains in the protection of workers was the keynote of the Seventh National Conference on Labor Legislation, which met in Washington on December 9, 10, and 11 at the call of the Secretary of Labor. The delegates attending represented the Governors of 35 States, Alaska, and Puerto Rico, and also the District of Columbia. They included labor department and trade-union officials and employer representatives.

In opening the conference, the Secretary of Labor pointed out the sharpening of many problems connected with labor standards which had come as a result of the defense emergency and stressed the importance of maintaining these standards unimpaired as a contribution to the national defense. Much of the conference activity centered about committee work. Child labor, industrial home work, and migratory labor were among the subjects considered by committees. Other committees were concerned with wages and hours, labor supply and national defense, and a number of other important labor topics.

The report of the committee on child labor, of which William H. Ivey of Alabama was chairman, was adopted by the conference after thorough discussion. This report reaffirmed the findings of the Sixth National Conference on Labor Legislation in 1939 as to the serious problems of child labor still existing and the necessity for preserving the standards and extending the controls established. The report commended the enforcement of the child-labor provisions of the Fair Labor Standards Act by the Children's Bureau and urged adequate appropriations to enable the Bureau to carry out fully its responsibilities under the act. With regard to State legislation, the committee urged that every State which had not yet done so amend its child-labor legislation to meet the standards recommended by the conference in 1939 and provide adequate funds and strengthen administration sufficiently to make those standards effective. The need was also recognized for an amendment to the Constitution of the United States giving authority to the Federal Government to do its part in cooperation with the States in eliminating the evil of child labor.

The committee placed particular emphasis upon the urgency of control of child labor in industrialized agriculture, the recommendations on this subject which were included in the report being as follows:

> We urge that the use of * * * children in industrialized agriculture be dealt with on the same basis as the employment of children in factories, in which the elements of exploitation are essentially the same. This involves the establishment of a 16-year minimum [age] for employment during school hours and 14 for all other times. In addition, for migratory children employed in industrialized agriculture, such protection also involves the requirement of decent housing standards with adequate sanitation, and education for all children of school age equal to that for resident children.

The committee also recommended complete prohibition of industrial home work through both State and Federal legislation as the only means of eliminating this type of child exploitation, double compensation for minors injured while illegally employed, and further regulation of child labor in street trades and on the stage. With regard to education, the committee expressed the belief that every community should reexamine and strengthen its educational program and that there should be substantial Federal appropriations to equalize educational opportunity for children throughout the country.

The report concluded with the following statement regarding the relation of child protection to the national defense:

> Speed-up in employment has always brought an increase in child-labor problems, particularly if there is the additional stress of emergency. We therefore must make sure that there is no relaxation of standards which might permit employment of boys and girls at immature ages.
>
> In strengthening the defense of the Nation, the item of greatest importance is safeguarding and promoting the health, safety, and morale of its workers. Particularly is this true of those youthful workers of legal age for employment during the period when they are being introduced to industry.
>
> The education and preparation of youth are basic to the preservation of our democratic ideals. The home, the church, and the school all have vital contributions to make. We therefore urge common planning and cooperative action in which all are working together in giving youth the best preparation for life and citizenship in a democracy.

The members of the committee on child labor were, in addition to William H. Ivey, chairman: Raymond W. Bellamy, Maryland; C. A. Fink, North Carolina; Courtenay Dinwiddie, National Child Labor Committee; Mrs. J. K. Pettengill, National Congress of Parents and Teachers.

Child Labor Day

In announcing the observance of January 25–27, 1941, as Child Labor Day the National Child Labor Committee points out that the last week end in January has been so designated for 35 years and states, "Radical changes have occurred in the child-labor picture since the first Child Labor Day. Many of the worst abuses are gone forever. But many thousands of children are still employed under conditions that threaten their health and their education. Efforts must not be relaxed."

Churches, schools, women's organizations, and civic agencies wishing to join in the observance of Child Labor Day are invited to write to the National Child Labor Committee (419 Fourth Avenue, New York) for further information, including a Child Labor Day packet (price, 25 cents).

National Social Hygiene Day

The American Social Hygiene Association has announced February 5, 1941, as the date set for the Nation-wide observance of the fifth National Social Hygiene Day.

More than 5,000 community meetings are scheduled in all parts of the country, and four regional conferences will be held—in Philadelphia, St. Louis, New Orleans, and Los Angeles—in connection with National Social Hygiene Day.

Efforts this year will be concentrated on safeguarding men and youths in military and naval training camps and workers in essential industries from venereal disease and on reducing commercialized prostitution. The Secretary of the Navy and the Secretary of War have endorsed this drive.

The November 1940 issue of *Social Hygiene News*, published monthly by the American Social Hygiene Association (1790 Broadway, New York), is in the form of a guide to Social Hygiene Day materials obtainable from the association. These include a motion-picture film, slide films, posters, placards, and books on sex education. In addition, a new leaflet about syphilis and gonorrhea, designed for young men about to enter the Army and Navy, has been released by the association for free distribution. This leaflet, So Long Boys, was written by Dr. Walter Clarke, executive director of the association, and gives the essential facts about syphilis and gonorrhea and the prevention of these diseases.

U. S. GOVERNMENT PRINTING OFFICE: 1941

CONFERENCE CALENDAR

Jan. 21–24 Council of State Governments. Biennial general assembly, Washington, D. C.

Jan. 24–26 National Public Housing Conference. New York, N. Y.

Feb. 9–16 Negro History Week. Sixteenth annual celebration. Information: Association for the Study of Negro Life and History, 1538 Ninth Street NW., Washington, D. C.

Feb. 13–15 American Camping Association. Eighteenth annual convention, Wardman Park Hotel, Washington, D. C. Permanent headquarters: 330 South State Street, Ann Arbor, Mich.

Feb. 19–22 Council of Guidance and Personnel Associations. Atlantic City, N. J.

Feb. 19–22 National Vocational Guidance Association. Annual convention, Atlantic City, N. J.

Feb. 20–21 International Council for Exceptional Children. New York. President: Dorothy E. Norris, State Board of Education, Cleveland, Ohio.

Feb. 20–21 Inter-American Bibliographical and Library Association. Fourth conference, Washington, D. C.

Feb. 20–22 American Orthopsychiatric Association. Eighteenth annual meeting, New York. Permanent headquarters: 1790 Broadway, New York.

Feb. 22–27 American Association of School Administrators. Atlantic City, N. J. Permanent headquarters: 1201 Sixteenth Street NW., Washington, D. C. Also, National Council of Childhood Education and other allied organizations.

Mar. 27–29 American Academy of Pediatrics. Meeting of Region 1, New Haven, Conn.

Apr. 29 Conference of State and Territorial Health Officers with the United States Public Health Service, Washington, D. C.

Apr. 30 Conference of State and Territorial Health Officers with the Children's Bureau, Washington, D. C.

UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU

KATHARINE F. LENROOT, CHIEF

THE CHILD is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives THE CHILD.

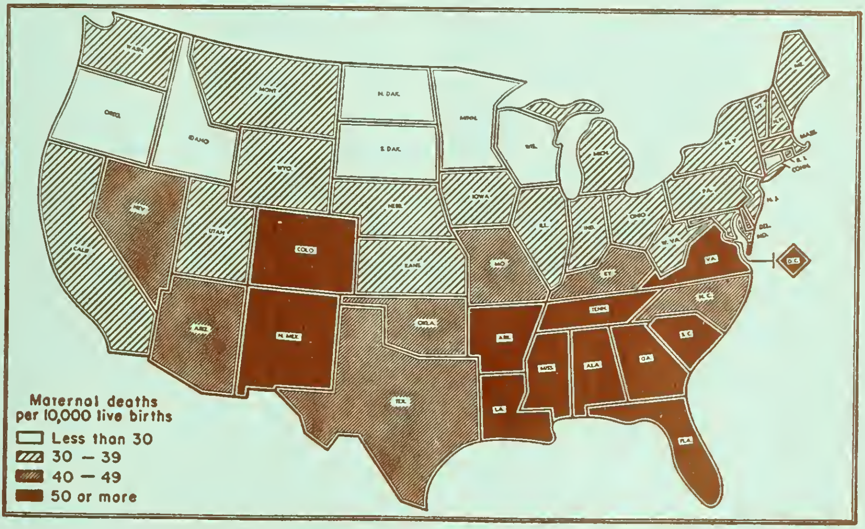
THE CHILD is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to the editor, THE CHILD, Children's Bureau, United States Department of Labor, Washington, D. C.

THE CHILD is for sale by the Superintendent of Documents, Washington, D. C., at $1 a year; foreign postage, $0.50 additional. Single copies are 10 cents each. Subscription orders should be addressed to the Superintendent of Documents, Government Printing Office, Washington, D. C.

The CHILD

Monthly Bulletin

MATERNAL MORTALITY RATES, BY STATE; UNITED STATES, 1939



U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

FEBRUARY 1941

THE CHILD

MONTHLY BULLETIN

Volume 5, Number 8

February 1941

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The Children's Bureau does not necessarily endorse or assume responsibility for the statements or opinions of contributors not connected with the Bureau.

• BIRTH • GROWTH • CHILD HEALTH •

Maternal and Infant Mortality in 1939 Lowest on Record

By Elizabeth C. Tandy, Sc. D.

Consultant on Infant and Maternal Mortality and Stillbirth Statistics, Division of Statistical Research, U. S. Children's Bureau

MATERNAL- and infant-mortality statistics for 1939 have just been issued by the United States Bureau of the Census. The maternal mortality rate for the year was 40 per 10,000 live births. The infant mortality rate was 48 per 1,000 live births. These are the lowest maternal and infant mortality rates on record for the United States. (The record covers the years 1915–39.)

The maternal mortality for 1939 was 9 percent lower than that for 1938 and 32 percent lower than that for 1934 (the year before the passage of the Social Security Act). The infant mortality rate for 1939 was 6 percent lower than that for 1938 and 20 percent lower than that for 1934. During the period 1930–34 the maternal mortality rate dropped only 12 percent; the infant mortality rate, only 8 percent. It will be noted that the decreases in both maternal and infant mortality rates have been greater during the 5 years of Federal and State cooperation under the Social Security Act than during the 5 previous years. The well-marked reductions indicate that work for improvement in maternal and child health is being successfully carried forward.

During the years in which reductions of considerable magnitude have been attained in maternal and infant mortality rates the decrease in the general death rate has been relatively small. The death rate from all causes for persons of all ages was 10.6 per 1,000 population in 1939 as compared with 10.7 in 1938. The decrease since 1934, when the rate was 11.1, amounts to only 5 percent. These general death rates are based on population estimates that take into consideration provisional population figures from the 1940 census.[1]

The birth rate for 1939 was 17.3 per 1,000 population. This is a slightly lower rate than that for 1938 (17.6) but a higher rate than that of any year from 1933 to 1937. These rates are also based on population estimates that take into consideration provisional population figures from the 1940 census.

Maternal Deaths

In 1939, 9,151 women died from conditions directly due to pregnancy and childbirth; 6,995 of these women were white women, 2,083 were Negro, and 73 were women of other races. The maternal mortality rate for Negro women (77) was more than double the rate for white women (35). The mortality rates for both white and Negro women have decreased, but the decrease during the years of cooperation under the Social Security Act has been greater among white women (35 percent) than among Negro (17 percent) (fig. 1 and table 1).

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[1] The information from the 1940 census is being released by the Bureau of the Census as it becomes available. The total population of the United States in 1940, as enumerated in the census, was 131,669,275. Preliminary figures based on a 5 percent cross section of the population show that there were about 45,461,000 persons under 20 years of age, 30,697,000 under 14 years, and 10,598,000 under 5 years of age in the United States in 1940.

The population of the United States was about 9 million greater in 1940 than in 1930, but there were about 3 million fewer children under 14 years and almost 1 million fewer children under 5 years in the United States in 1940 than in 1930. The smaller numbers in the child population in 1940 are a direct result of the decrease in the birth rate. In the past 25 years the birth rate has declined by more than one-fourth. This decrease has been compensated for only in small part by the reduction of 52 percent in the infant mortality rate.

TABLE 1.—*Maternal mortality rates,[1] by race; United States expanding birth-registration area, 1930–39*

Year	Total	White	Negro
1939	40	35	77
1938	44	38	86
1937	49	44	86
1936	57	51	98
1935	58	53	95
1934	59	54	93
1933	62	56	100
1932	63	58	100
1931	66	60	112
1930	67	61	119

[1] Maternal deaths per 10,000 live births.

The maternal mortality rates for the States vary widely. Seven States had rates of less than 30 per 10,000 live births; 22 had rates of 30 to 39; 8, 40 to 49; and 12 had rates of 50 or higher. The States with the highest rates were Florida (65) and Louisiana (62). The States with the lowest rates were Idaho (22), North Dakota (24), and Oregon (24). The rate of Idaho is the lowest rate ever recorded for any State (fig. 2, see cover, and table 2).

In 31 States and the District of Columbia the maternal mortality rates were lower than in 1938, in 12 States the rates were higher, and in 5 States the rate was the same as that of the prior year. In none of the States with increases was the increase sufficient to be statistically significant in view of the number of live births involved. Statistically significant decreases occurred in 6 States: Georgia, Idaho,

TREND OF MATERNAL MORTALITY RATES, BY RACE; UNITED STATES EXPANDING BIRTH-REGISTRATION AREA, 1930-39

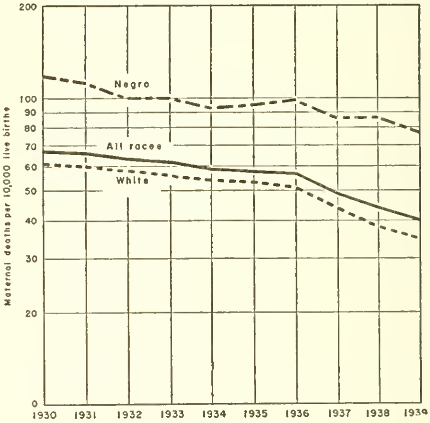

FIGURE 1.

TABLE 2.—*Maternal mortality rates, by State; United States, 1939 and 1938*

State (number of deaths in 1939)	Maternal mortality rate[1]	
	1939	1938
United States (9,151)	40	44
Alabama (361)	59	68
Arizona (48)	44	48
Arkansas (202)	57	55
California (321)	31	33
Colorado (111)	54	45
Connecticut (60)	26	26
Delaware (18)	41	56
District of Columbia (73)	52	56
Florida (211)	65	75
Georgia (362)	56	67
Idaho (24)	22	41
Illinois (370)	31	34
Indiana (210)	36	37
Iowa (131)	30	33
Kansas (108)	37	41
Kentucky (262)	43	42
Louisiana (302)	62	59
Maine (59)	39	46
Maryland (105)	37	38
Massachusetts (224)	35	39
Michigan (289)	31	37
Minnesota (148)	29	28
Mississippi (307)	59	59
Missouri (243)	41	39
Montana (35)	32	33
Nebraska (78)	35	35
Nevada (8)	41	32
New Hampshire (27)	34	38
New Jersey (182)	32	37
New Mexico (71)	50	57
New York (603)	32	38
North Carolina (374)	47	53
North Dakota (32)	24	24
Ohio (424)	39	38
Oklahoma (176)	40	42
Oregon (40)	24	35
Pennsylvania (613)	38	39
Rhode Island (35)	34	28
South Carolina (253)	59	79
South Dakota (34)	29	36
Tennessee (297)	56	56
Texas (590)	49	56
Utah (40)	31	30
Vermont (23)	36	37
Virginia (268)	51	53
Washington (95)	36	33
West Virginia (136)	33	39
Wisconsin (151)	28	29
Wyoming (17)	35	32

[1] Maternal deaths per 10,000 live births.

Michigan, New York, South Carolina, and Texas.

More detailed information is available on the causes of maternal death in 1939 than in previous years, for the deaths of 1939 were tabulated in accordance with the 1938 revision of the International List of Causes of Death. The section on causes of maternal deaths was designed to afford information in accordance with recommendations of the American Committee on Maternal Welfare. Deaths certified as due to criminal abortion are now classified as maternal deaths. (Such deaths were classified as homicide in earlier revisions of the International List; as they numbered only 157 in 1939, their inclusion does not materially affect comparability of maternal deaths with those of prior years.)

About three-fifths (5,613) of the 9,151 women whose deaths were classified as maternal in 1939 died during or after childbirth, but 24 percent (2,160) died during or after abortion or ectopic gestation, and 15 percent (1,378) died undelivered. The term "childbirth" in the 1938 revision of the International List is defined as the termination of a uterine pregnancy after 7 lunar months (28 weeks) or more of gestation. Abortion is defined as the termination of a uterine pregnancy prior to 7 lunar months (28 weeks) of gestation. It is pointed out that deaths from ectopic pregnancy usually occur at an early period of gestation during or after the expulsion or extraction of the extrauterine product.

Of the 5,613 women who died during or after childbirth, 42 percent (2,353) died from infection, 29 percent (1,617) from hemorrhage, trauma, or shock, 20 percent (1,149) from toxemias of pregnancy, and 9 percent (494) from other and unspecified conditions of childbirth and the puerperium (table 3).

Of the 2,160 women whose deaths are considered under the heading abortion and ectopic gestation 1,786 died after the expulsion or extraction of a uterine product, but the products of 374 were extrauterine. Infection was the cause of more than two-thirds of these deaths. Two hundred and twenty of these abortions were stated to have been self-induced; only 157 were stated to have been induced for nontherapeutic reasons by persons other than the woman herself. (Practically all (351) of these 377 women who had had self-induced or criminal abortions died from infection.) Toxemias of

TABLE 3.—*Maternal deaths from each cause, and time of death with respect to delivery; United States, 1939*

Cause of death	Total	Abortion and ectopic gestation	Before delivery	During or after childbirth
	Number			
All causes	9,151	2,160	1,378	5,613
Infection	3,834	1,481		2,353
Toxemias of pregnancy	2,232	93	990	1,149
Eclampsia	1,135		429	706
Albuminuria and nephritis	551		258	293
Other toxemias	546	93	303	150
Hemorrhage, trauma, and shock	1,808	130	61	1,617
Other specified causes	471	456		15
Cause not stated	806		327	479
	Percent distribution			
All causes	100	100	100	100
Infection	42	69		42
Toxemias of pregnancy	24	4	72	20
Eclampsia	12		31	12
Albuminuria and nephritis	6		19	5
Other toxemias	6	4	22	3
Hemorrhage, trauma, and shock	20	6	4	29
Other specified causes	5	21		(1)
Cause not stated	9		24	9

---

[1] Less than 1 percent.

pregnancy were the cause of only 93 of these 2,160 deaths.

About three-fourths of the 1,378 women who died undelivered died from toxemias of pregnancy; 61 died from hemorrhage. For 327 of these deaths the physician gave no real information as to the cause but merely entered the fact of pregnancy or that the mother died before the baby was born.

The principal causes of death were infection, toxemias of pregnancy, and hemorrhage, trauma and shock. These three causes were responsible for 86 percent of the 9,151 maternal deaths.

Infection was responsible for 42 percent of the 9,151 deaths. Most of the women who died from this cause died during or after childbirth but 1,393 died during or after abortion and 88 women, from ectopic gestation. In the majority of instances death was due to infection classified as general or local, but thrombophlebitis, embolism, and sudden death were responsible for 715 deaths and pyelitis and pyelonephritis for 112.

Toxemias of pregnancy were responsible for 24 percent (2,232) of the 9,151 deaths. Slightly more than half of these 2,232 women died during or after childbirth, 44 percent died before delivery, and 4 percent during or after abortion. Eclampsia was responsible for 51 percent of these deaths, albuminuria and nephritis not specified as chronic for 25 percent, and other toxemias for 24 percent.

Hemorrhage, trauma, and shock were responsible for 20 percent (1,808) of the 9,151 deaths. Most of these 1,808 deaths occurred during or after childbirth, but 130 were due to hemorrhage during or after abortion and 61, to hemorrhage of pregnancy. Placenta previa was mentioned for 288 of these 1,808 deaths; premature separation of the normally implanted placenta, for 196.

Deaths shown as due to other specified causes numbered 471. Of these deaths 170 were from abortion, 286 from ectopic gestation, 2 from infection of the breast during lactation, and 13 from psychosis of the puerperium. It appears probable that most of the deaths that followed abortion and most of the deaths from ectopic gestation were really due either to infection or to hemorrhage, trauma, and shock.

Physicians failed to give satisfactory information as to cause of death for 9 percent (806) of the 9,151 maternal deaths. These deaths include 327 that occurred before delivery for which the physician stated the cause in general terms such as pregnancy, multiple pregnancy, or dead fetus in utero, and 479 that occurred during or after childbirth for which the physician's statement indicated little more than that a child had been born to the mother and that the birth was the most important factor in the death. The lack of information for these considerable numbers of deaths calls attention to the need for improvement in stating cause on the death certificates.

INFANT DEATHS

The number of infant deaths in 1939 was 108,846. Slightly more than half (53 percent—57,778) of these infants died in rural areas; slightly less than half (47 percent—51,068) died in urban areas, that is, in cities of 10,000 or more population. Of the infants who died in their first year of life 87,841 were white, 19,755 were Negro, and 1,250 were of other races.

The infant mortality rates for both urban and rural areas and for both white and Negro infants have decreased markedly in recent years. The 1939 rates in urban areas (45) and rural areas (51) and for white (44) and Negro infants (73) are all-time low records. It is noteworthy, however, that the rate in rural areas is somewhat higher than the rate in cities and that the rate for Negroes is considerably higher than that for white infants (table 4).

TABLE 4.—*Infant mortality rates,[1] by area and race; United States expanding birth-registration area, 1930–39*

Year	Total	Urban areas	Rural areas	White infants	Negro infants
1939	48	45	51	44	73
1938	51	48	54	47	78
1937	54	52	57	50	82
1936	57	55	59	53	86
1935	56	54	57	52	82
1934	60	58	62	55	91
1933	58	57	59	53	85
1932	58	57	58	53	84
1931	62	61	62	57	93
1930	65	63	66	60	100

[1] Deaths in the first year of life per 1,000 live births.

The infant mortality rates of the States varied widely. Oregon set a new all-time low record for States (35); two States, Connecticut and Minnesota, had rates of 36. At the other end of the scale were Arizona with a rate of 94 and New Mexico with a rate of 109. Thirteen States had rates of less than 40 per 1,000 live births, 23 had rates of 40 to 54, 11 had rates from 55 to 69, and 2 had rates of 70 or more. Ten of the 13 States that had rates of 55 or higher in 1939 were Southern States, 3 were Western States (fig. 3, p. 195, and table 5).

TABLE 5.—*Infant mortality rates, by State; United States, 1939 and 1938*

State (number of deaths in 1939)	Infant mortality rate [1]	
	1939	1938
United States (108,846)	48	51
Alabama (3,675)	60	61
Arizona (1,031)	94	99
Arkansas (1,637)	46	51
California (4,385)	42	44
Colorado (1,134)	55	60
Connecticut (842)	36	36
Delaware (193)	44	53
District of Columbia (669)	48	48
Florida (1,822)	56	58
Georgia (3,780)	58	68
Idaho (508)	46	45
Illinois (4,474)	38	41
Indiana (2,302)	39	43
Iowa (1,697)	39	41
Kansas (1,146)	39	43
Kentucky (3,187)	53	61
Louisiana (3,077)	63	67
Maine (785)	52	56
Maryland (1,422)	50	56
Massachusetts (2,358)	37	40
Michigan (3,955)	42	45
Minnesota (1,798)	36	39
Mississippi (2,907)	56	57
Missouri (2,655)	45	52
Montana (534)	49	46
Nebraska (816)	37	36
Nevada (87)	45	48
New Hampshire (363)	46	48
New Jersey (2,184)	39	40
New Mexico (1,549)	109	109
New York (7,370)	39	41
North Carolina (4,683)	59	69
North Dakota (645)	49	50
Ohio (4,691)	43	43
Oklahoma (2,162)	50	49
Oregon (593)	35	39
Pennsylvania (7,343)	46	46
Rhode Island (412)	39	44
South Carolina (2,834)	66	80
South Dakota (481)	41	44
Tennessee (2,874)	54	63
Texas (8,110)	67	65
Utah (514)	40	47
Vermont (291)	46	48
Virginia (3,221)	61	66
Washington (976)	37	39
West Virginia (2,272)	55	62
Wisconsin (2,179)	40	42
Wyoming (223)	46	52

[1] Deaths in the first year of life per 1,000 live births.

In 39 States infant mortality rates were lower in 1939 than in 1938; in 5 States the rates were higher; in 4 States and the District of Columbia the rates were the same as in 1938. Statistical test shows that in none of the 5 States with higher rates were the increases sufficient to be statistically significant in view of the number of births involved. Statistically significant decreases occurred in 20 States. These States are: Arkansas, Colorado, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New York, North Carolina, South Carolina, Tennessee, Utah, Virginia, and West Virginia.

BIRTHS

The number of live births registered in 1939 was 2,265,588. About half (1,138,185) of these births occurred in rural areas; the other half (1,127,403) in urban areas, that is, in cities of 10,000 or more population. Of the infants whose births were registered, 1,982,671 (87 percent) were white; 270,060 (12 percent) were Negro; 12,857 (1 percent) were of other races.

Physicians attended 90 percent of these births, but almost a quarter of a million births (221,231) were attended by midwives and other nonmedical persons. Relatively few births in cities (2 percent) and relatively few births of white infants (4 percent) were attended by nonmedical persons, but the proportion in rural areas was 17 percent and that for Negro infants, 53 percent.

Slightly more than half (51 percent) of all the births in the United States occurred in hospitals; but 81 percent of all the births in cities occurred in hospitals in contrast to 22 percent of the births in rural areas. Of all white infants 55 percent were born in hospitals; of Negro infants, 23 percent.

The proportion of births in hospitals has increased considerably during the period of record. In 1935 (the first year for which information on attendant at birth was issued by the Bureau of the Census) 37 percent of the live births occurred in hospitals as compared with 51 percent in 1939. There has been a slight decrease in the proportion of births attended by nonmedical persons during these years; it was 12 percent in 1935 compared with 10 percent in 1939. The decrease in births attended by physicians in homes is well marked; the proportion dropped from 51 percent in 1935 to 39 percent in 1939 (fig. 4).

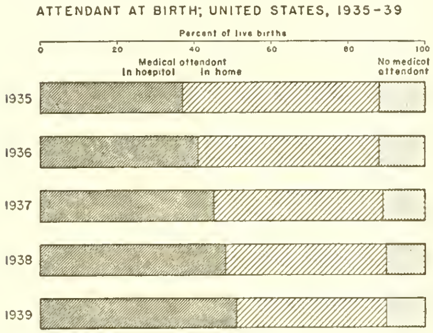

FIGURE 4.

In the District of Columbia and the highly urbanized States of New York, Massachusetts, Connecticut, New Jersey, and Rhode Island, and in the far western States of Washington, Oregon, California, and Nevada three-fourths or more of the births in 1939 occurred in hospitals, and relatively few failed to receive medical attention (in none of these States was the proportion of births attended by nonmedical persons as high as 3 percent). In Alabama, Arkansas, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and West Virginia (these are States where many births occur in rural areas and many Negro infants are born) less than one-fourth of all the births occurred in hospitals. In each of these States except Kentucky and West Virginia, 25 percent or more of the infants were born without medical attention; these States include Mississippi, where 49 percent of the births were not attended by physicians, South Carolina (45 percent), Georgia (37 percent), Alabama (34 percent), North Carolina (26 percent), Arkansas (25 percent). These States that had relatively few births in hospitals and many births not attended by physicians were States that had high infant and maternal mortality rates. Practically all the States that had a large proportion of births in hospitals and few births attended by nonmedical persons had mortality rates for their mothers and infants lower than those for the United States as a whole (fig. 5 and table 6).

TABLE 6.—*Attendant at birth, by State; United States, 1939*

State (number of live births in 1939)	Percent attended by—		
	Physician		Nonmedical person
	In hospital	In home	
United States (2,265,588)	51.1	39.1	9.7
Alabama (61,385)	17.5	48.3	34.2
Arizona (10,928)	52.2	38.9	8.9
Arkansas (35,565)	14.2	60.5	25.3
California (103,453)	82.8	16.2	.9
Colorado (20,692)	55.7	42.8	1.5
Connecticut (23,463)	87.9	11.3	.7
Delaware (4,384)	63.8	25.1	11.1
District of Columbia (14,037)	89.9	10.1	------
Florida (32,328)	38.5	34.0	27.4
Georgia (64,781)	24.3	38.8	36.9
Idaho (11,068)	55.3	44.3	.4
Illinois (117,841)	69.5	30.0	.5
Indiana (58,349)	46.6	53.1	.3
Iowa (43,765)	52.7	47.1	.1
Kansas (29,115)	47.2	52.6	.2
Kentucky (60,587)	15.6	65.9	18.5
Louisiana (48,844)	36.3	30.1	33.6
Maine (14,987)	43.2	56.8	------
Maryland (28,291)	54.6	37.2	8.2
Massachusetts (63,657)	81.5	18.2	.3
Michigan (94,418)	57.2	42.3	.6
Minnesota (50,237)	63.9	34.3	1.7
Mississippi (51,721)	11.6	39.0	49.3
Missouri (58,876)	44.7	50.8	4.5
Montana (10,897)	72.6	25.5	1.9
Nebraska (22,338)	47.7	52.1	.1
Nevada (1,940)	75.5	22.2	2.2
New Hampshire (7,934)	70.8	29.1	.1
New Jersey (56,379)	80.4	16.8	2.8
New Mexico (14,215)	25.2	42.6	32.3
New York (187,575)	84.6	14.4	1.0
North Carolina (79,149)	21.2	52.8	26.1
North Dakota (13,158)	54.2	39.6	6.3
Ohio (109,272)	57.1	42.7	.1
Oklahoma (43,471)	31.8	64.1	4.2
Oregon (16,715)	78.5	21.2	.4
Pennsylvania (161,049)	57.7	41.6	.6
Rhode Island (10,444)	75.3	23.4	1.3
South Carolina (42,811)	16.0	38.9	45.1
South Dakota (11,616)	51.0	47.9	1.1
Tennessee (53,353)	25.1	63.5	11.4
Texas (121,049)	37.5	46.0	16.5
Utah (13,007)	62.6	36.4	1.0
Vermont (6,375)	50.7	49.2	.1
Virginia (52,921)	24.9	49.5	25.6
Washington (26,538)	83.0	16.9	.1
West Virginia (41,545)	16.3	78.1	5.6
Wisconsin (54,168)	53.5	45.8	.7
Wyoming (4,897)	58.5	40.6	.9

SUMMARY

The reductions in maternal and infant mortality rates attained in 1939 and in all the 5 years

INFANT MORTALITY RATES, BY STATE; UNITED STATES, 1939

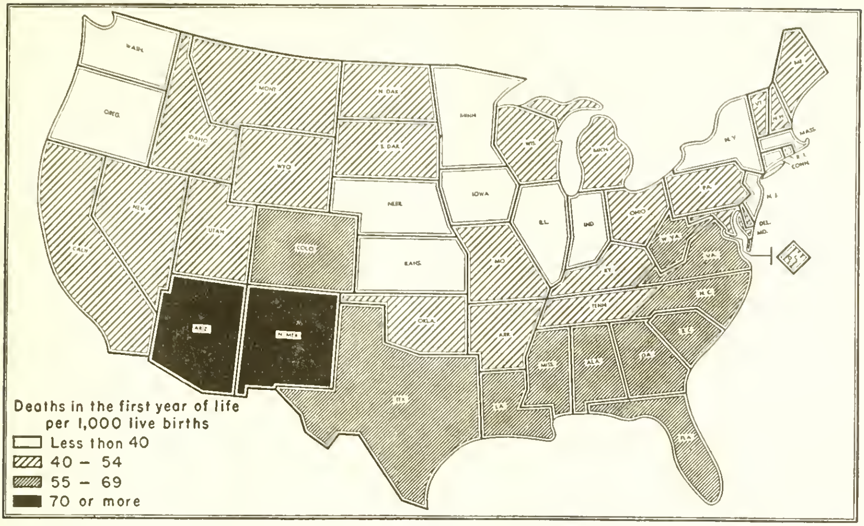

FIGURE 3.

PERCENTAGE OF LIVE BIRTHS THAT OCCURRED IN HOSPITALS IN EACH STATE; UNITED STATES, 1939

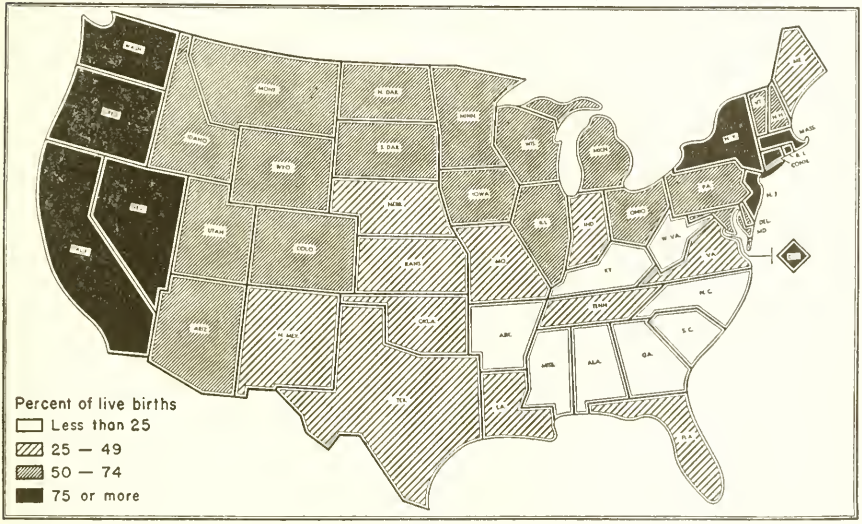

FIGURE 5.

of Federal and State cooperation under the Social Security Act are well marked. Eleven thousand mothers and 75,000 babies were saved during the period 1935–39 who would have died had mortality rates of 1934 prevailed throughout, and 800 mothers and 6,700 babies were saved in 1939 who would have died had mortality been as high in that year as it was in 1938.

Much remains to be done: many needless deaths occur each year, especially among the Negroes. The accomplishments of recent years, however, may well give encouragement to all who are working to improve the health situation of mothers and babies.

BOOK NOTES

Nutrition

Feeding the Family, by Mary S. Rose. Fourth edition. Macmillan Co., New York, 1940. 421 pp. $5. (College edition $3.75.)

Food, Nutrition and Health, by E. V. McCollum and J. Ernestine Becker. Fifth edition. Published by the authors, East End Post Station, Baltimore, Md., 1940. 128 pp. $1.50.

Essentials of Nutrition, by Henry C. Sherman and Caroline S. Lanford. Macmillan Co., New York, 1940. 418 pp. $3.50.

The American and His Food, by Richard O. Cummings. University of Chicago Press, Chicago, 1940. 267 pp. $2.50.

All these books are written in nontechnical language. The first two are current editions of popular nutrition books that have met the test of time.

Feeding the Family, which is set in large type with many attractive illustrations and which deals with the food needs of various members of the family group, is likely to appeal to heads of households faced with the very task indicated by the title.

Food, Nutrition and Health is a compact volume that strikes a modern note by beginning with the vitamins and proceeding to the other essential dietary factors; it deals with the nutrition problems of whole populations as well as of the individual.

Essentials of Nutrition is intended primarily as an elementary text for students with little background of science; it calls, however, for a breadth of understanding and interest. Perhaps its outstanding characteristic is its treatment of nutrition in general and of the individual dietary factors in terms of their contribution to human welfare. The list of suggested readings at the end of each chapter adds to the value of the book as a starting point for the study of nutrition in its more technical aspects.

The American and His Food is the work of a historian who thinks that man's food habits are as worthy of record as his other activities and who has delved deeply into sources dating from the beginnings of the republic and including current Government reports. Food supplies and food habits in this country are shown to have been influenced by technological developments, transportation, refrigeration, storage, and research and also by the more human elements of fashion, efforts of food reformers, and dissemination of scientific knowledge of food values. This volume presents a great deal of information in small compass and provides perspective for the understanding and evaluation of national nutrition policies. M. M. H.

Human Nutrition. U. S. Department of Agriculture, Yearbook Separate No. 1668. Reprint of Part 1 of the Yearbook of Agriculture, 1939, pp. 97–402; 1075–1142. Washington, 1940. 40 cents.

Students of nutrition have turned again and again in the past year to Food and Life, the 1939 Yearbook of Agriculture. It is a great convenience to have in less bulky form part 1, dealing with human nutrition, and the complete bibliography.

The Changing Front of Health. Proceedings of the Eighteenth Annual Conference of the Milbank Memorial Fund, April 2 and 3, 1940, at the New York Academy of Medicine. Milbank Memorial Fund, New York, 1940. 104 pp.

As in previous years, nutrition was one of the subjects under discussion at the 1940 annual conference of the Milbank Memorial Fund. The discussion is summarized in two articles in the proceedings. Dr. Allen W. Freeman reported on the session concerned with the relation of diet and nutrition to public health, which dealt with community programs and with the professional preparation of workers in the field of nutrition. Dr. Thomas Parran summarized results obtained on the medical appraisal of the state of nutrition, after a round-table discussion on that subject.

Vitamins and Their Occurrence in Foods, by Hazel E. Munsell. Reprinted from *Milbank Memorial Fund Quarterly*, Vol. 18, No. 4 (October 1940), pp. 311–344. 10 cents.

This article gives a brief and comparatively nontechnical presentation of present-day knowledge of the properties and food sources of the vitamins known or believed by most investigators to be essential to man. Methods for quantitative determination of the vitamin values of foods are described and the limitations in the significance of small differences in values are pointed out. There is a table, expressed in units per 100 grams, of the values of common foods in vitamins A, B_1, C, D, and riboflavin (G).

FOOD VALUES OF PORTIONS COMMONLY USED, by Anna dePlanter Bowes and Charles F. Church. Third edition revised. Philadelphia Child Health Society, Philadelphia, 1940. 31 pp. $1; order from Anna de Planter Bowes, 311 S. Juniper St. Philadelphia.

The purpose of this booklet, published originally in 1937, is to supply data on food values of foods as they are served. It is intended for easy reference by students of medicine, dentistry, dental hygiene, and public-health nursing, but it seems to have been found useful by other professional groups and by homemakers.

THE SCHOOL LUNCH AS A SUPPLEMENT TO THE HOME DIET OF GRADE SCHOOL CHILDREN, by Mary Eleanor Lowther et al. *Child Development*, Vol. 11, No. 3 (September 1940), pp. 203–247.

Tests were made on 225 children in two urban communities to find from dietary records and nutritional-status measurements what should constitute a satisfactory noonday meal to supplement the morning and evening diets of children of various socioeconomic groups. The findings "clearly indicate the need for improvement in nutritional status of a considerable proportion of the children in all socioeconomic groups, with this need becoming more acute as the socioeconomic level becomes lower."

Child Development

A STUDY OF THE TREND OF WEIGHT IN WHITE SCHOOL CHILDREN FROM 1933 TO 1936, by Georg Wolff, M. D. *Child Development*, Vol. 11, No. 3 (September 1940), pp. 159–180.

Based on an extensive investigation of the growth of white school children 6 to 16 years of age in Hagerstown, Md., this paper is the first of a series dealing with the pattern of growth and annual variations in the height and weight of children. The material was collected by the United States Public Health Service and is to some extent a continuation of former studies of the growth of school children of the same community published by Palmer.

Maternal and Infant Health

EXPECTANT MOTHERHOOD, by Nicholas J. Eastman, M. D. Little, Brown & Co., Boston, 1940. 176 pp. $1.25.

Written for intelligent expectant mothers, this book supplements and emphasizes the advice given by the attending physician. The scope of the book is indicated by the chapter headings: Signs and Symptoms of Pregnancy, Growth and Development of the Fetus, Diet and Hygiene in Pregnancy, Common Discomforts and Their Treatment, Danger Signals, Preparations for the Baby, The Birth of the Baby, "Painless Childbirth," Convalescence from Childbirth, and The Newborn Baby.

Major emphasis is given to the importance of competent medical supervision throughout pregnancy, diet in pregnancy, and hygiene during pregnancy.

The author's insight into the mind of the pregnant woman is shown in his simple, concise, and accurate answers to the innumerable questions which the patient often hesitates to ask her busy physician.

E. F. D.

SYPHILIS IN MOTHER AND CHILD. U. S. Public Health Service, Supplement No. 7 to Venereal Disease Information, Washington, 1940. 20 pp.

Part 1 contains a discussion of syphilis in pregnant women and its diagnosis and treatment. Part 2 deals with the diagnosis of early congenital syphilis, clinical manifestations of late congenital syphilis, and the discovery, treatment, and prognosis of congenital syphilis.

Public Health

PUBLIC HEALTH IN NATIONAL DEFENSE, by W. S. Leathers. *American Journal of Public Health*, Vol. 30, No. 11 (November 1940), pp. 1269–1275.

In this paper, the presidential address before the American Public Health Association at its sixty-ninth annual meeting, held in Detroit in October 1940, Dr. Leathers discusses principles and measures of concern in maintaining the public-health gains already made and in developing and stabilizing an adequate medical and public-health program in national defense. After summarizing the problem of disabling infections in the Army and Navy and the importance of immunization general sanitation, continued scientific research, and nutrition, he states:

> Since the lives of children are of primary concern to the Nation even when no emergency exists, and because children are the greatest sufferers in times of stress and emergency, plans for safeguarding their welfare must have a prominent place in national defense. Serious dislocations of family life will be inevitable and will require that ample provision be made for increased medical, nutritional, and welfare services for children in all communities.

In concluding Dr. Leathers commends the present efforts of State health agencies to provide qualified personnel by a merit system.

Citizen Participation in Child-Welfare-Service Programs

By Mary S. Labaree

Child Welfare Division, U. S. Children's Bureau

One of the chief problems faced by all social workers, especially by the child-welfare workers who are developing new programs of local services to children in rural areas, is that of interpreting their activities to the communities in which they work. If local public opinion does not understand or support their efforts in behalf of children the program cannot take root.

"But what is it that you do?" is one question that workers in child-welfare services meet frequently. Another is, "Just what is a child-welfare case?" and still other queries may take some form of complaint, such as, "I don't see why you help the Blanks—they're no good anyway."

It is generally conceded that good case work is the best method of interpretation, but how may knowledge of the worker's services to children be disseminated? Interpretation is a different thing from mere publicity. A variety of devices have been tried in order to establish a basis for community acceptance of the program, but of them all the most important has been the drawing in of citizens to plan programs and to consider ways and means of preventing social situations creating child-welfare problems. Dr. Carstens, the late executive director of the Child Welfare League of America, once said that participation by citizens is the best remedy for a lack of knowledge of what needs to be done. By taking part in the work, he said, citizens "get ideas both as to the complexity of the problem and as to some of the fundamentals of treatment."

One way of utilizing this citizen interest has been through the organization of advisory committees, sometimes on a State-wide basis to give assistance in planning the entire program of child-welfare services, and sometimes as advisory groups to local child-welfare units. These committees have taken diverse forms in the several States. For instance, a group may be called to meet only once to advise on a special problem or case.

In one Arizona county this was tried in an adoption case. The county judge called together an informal group, including a probation officer, a child-welfare worker, a minister, and two county attorneys to help him decide whether to approve an adoption. The discussion was based on the worker's study of the home and on her recommendation that it be disapproved. The comments of those present made it evident that they had received a new conception of what was involved in foster-home placement of children and in legal adoption. They realized, as they had not realized before, that the child-welfare worker had a service to offer to all children in the community, and they were not slow to pass the word along. The county attorney was interested enough later to discuss adoption standards at length and to ask the child-welfare worker to make several of the adoptive-home studies that he had previously entrusted to deputy sheriffs.

Use of a similar committee was made in Kentucky when the needs of an unmarried mother who had drifted into the county seat from another State came to the attention of several individuals, churches, and welfare agencies and resulted in great though uncoordinated activity. The child-welfare worker called the various groups together, and a thoughtful plan for the girl and her baby was finally made, based on the facts the worker had been able to obtain. From this the community saw the value of thorough investigation and of social planning in a situation of this kind. Since then similar groups have been used in that county for other problems as they have arisen.

More formally organized advisory groups with more regular duties have been found successful in other places. They offer to citizens opportunities to learn about conditions in their own communities and to participate directly in the child-welfare program. Various activities of committee members have been reported.

In Pennsylvania one county committee raised $295, which was used for spending money and Christmas presents for 133 children under care; in another county the committee appointed a subcommittee to report on the county children's home but, as a body, was particularly concerned to protect the local program of child-welfare services by interpreting it to the new county commissioners when they took office. A delegation was sent to visit the new board soon after its election to explain the need for the services.

According to many child-welfare workers a committee may be an asset, but its organization should be attempted only when it can serve a real purpose and can be given wise leadership. To have a committee just for the sake of having one, before a community is ready for group discussion of social problems, accomplishes little. The difficulty of giving the members enough to do to maintain their interest and to keep them from attempting actual case work themselves is real, and, in the opinion of most workers, it is not the part of wisdom to undertake a formal organization of committee service without a clear plan of how it may best be utilized.

In some State programs it has been helpful to have a professional advisory committee made up of those who have a broader interest in child welfare than that bounded by one community.

In Massachusetts special recognition has been given to the importance of the collaboration of private and public agencies through the appointment of a committee that has been functioning for more than a year. It is made up of executives of the leading private child-welfare organizations in the State, and it has participated in the making of the Massachusetts plan for child-welfare services. The committee shared first in the planning of a State-wide study of public and private resources for child welfare in all its phases. Federal funds through child-welfare services were provided, and a member of the staff of a private agency was given leave of absence to make the study. On its completion the committee participated in interpreting the findings throughout the State.

Another type of State-wide committee is used in Indiana, where a representative group of nonprofessional persons have been studying with the Child Welfare Division the needs of children in the State. Subcommittees have taken over the responsibility of developing with institution and agency workers standards for children's homes and for other child-caring organizations. When these have been finally drafted they will be recommended for approval to the State Department of Public Welfare.

Local case committees made up of professional and nonprofessional members are frequently found helpful. From a better understanding of the complexity of a child's problems and of the need for many different facilities in solving them there may be evolved an educational process that reaches beyond the walls of the committee room.

In Buncombe County, N. C., the advisory committee, whose interest in local child-welfare needs had been stimulated by a survey conducted by the Asheville Community Chest, decided to begin their work by discussion of basic information on local situations made available to them. As soon as the committee members have familiarized themselves with this material they plan to divide into smaller groups for further study of ways to meet the needs not now provided for in the field of child welfare.

Pennsylvania has as part of its plan a county-wide citizens' group to act as an advisory board for child-welfare services, and it reports that participation by local citizens is slow but steadily growing. A quotation from a report of one of the most completely rural Pennsylvania counties indicates that the county worker receives much help from her advisory board in interpreting the program:

> Some of our most interested members live at considerable distance from the office. This is not a community of wealth, and our board members are practically all busy men and women who have other duties. In the summer some of them take vacations, others run small hotels or boarding houses. In the winter bad weather and icy roads interfere with travel. We feel that the poor attendance does not, however, indicate that board members are not interested. One member, who has not attended more than four meetings, has undoubtedly spread the message of the work which this office is doing to many people in her community, and we cannot doubt that she is a devoted, interested member. Another member of the board lives 28 miles from here and does not drive a car. She sometimes comes up on a milk truck earlier in the day in order to be here for the meeting. We finally decided that we should enlarge our board and have recently added seven new members whom we have chosen from among people who have said that they could and would attend the monthly meetings.

In Pennsylvania, public child-welfare services are in some counties taking over work that was begun years ago by the private Children's Aid Society of Pennsylvania and that has been conducted under private auspices ever since. In these counties the public program is benefiting from the interest in standards of work and of personnel and from the knowledge of child-welfare work that local citizens have gained as board or committee members of the private society. Also, continuity during the transition period from private to public auspices has been made possible because of the responsibility for the program felt by those who had been supporting the work for children. The willingness of these board members to lose their identity and submerge their agency in the newly developed public service to children, while at the same time using their experience and their influence as voters and taxpayers to safeguard the program under its new direction, is a fine example of the value of citizen understanding to a public child-welfare program.

Family Living in Rural Missouri[1]

By Elisabeth Tuttle

Child-Welfare Worker, Cape Girardeau, Mo.

In isolated areas with a homogeneous population, such as the Ozark region of southwest Missouri, the family tree retains its full importance, even to the third twig on the fifth branch of the second limb. Each individual in the small community has a pedigree: He is not just John Jones, the tie hacker, but John Jones whose father is James A. Jones, who married Preacher Adams' second daughter; his grandfather is Peg-Leg Jones, who drinks and never was worth a cent; and none of the Joneses ever will ever be worth anything in the opinion of the community. This attitude has its positive as well as its negative side. The community may see little Johnny merely as one of the Jones tribe, but so do the Joneses. And if little Johnny gets in trouble, all the Joneses are solidly behind him even to Great-Grandfather Peg-Leg. Cannot this strong family solidarity be an important factor in giving Johnny the feeling of "belonging"?

Child-welfare workers are likely to be most conscious of the strength of family ties when faced with the necessity of severing them. How often we find that, when a child in a family which seems on the surface to offer him nothing is placed in another home, he is dissatisfied and unhappy, because the ties to his own people are too strong and too deeply rooted for him to be successfully transplanted. Recently we talked with the 21-year-old sister of some children who were being grossly neglected. Years before, this sister had gone to live with her grandmother, and she had developed standards and ambitions higher than those of her parents. She could see all their failings and shortcomings; her father's inability to hold a job; her mother's failure to face her responsibilities; the crowded and dirty home. In spite of all this, she begged us to persuade and help her parents to keep the younger children with them so that they can have that "family feeling." "I can't express it," she said, "but I'll always have the feeling that I missed something, because I didn't grow up with my own parents like other children."

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[1] Paper given at the session on Strengths in Family Life, State Conference of the Missouri Association for Social Welfare, April 13, 1940.

The child-welfare worker hears so often that what Johnny needs is a "good farm home," that she sometimes wonders if this is not just a convenient way of getting Johnny out of sight. In analyzing the reasons, however, why this is frequently the recommendation, I am forced to the conclusion that there is more to it than that. For example, there was 14-year-old Charles, deserted by his mother and left with an openly hostile and despotic father. When his own home became unbearable, Charles ran away and placed himself in a "good farm home." When he was visited there the next summer all his conversation was, "You should see my calf. Dad and I milk seven cows. He's going to let me plow with the tractor when I am old enough." And so on, far beyond the visitor's knowledge of farming. Charles was getting from this much more than occupation for his idle moments and more than training in agriculture. He was participating in the very life of the family, both its business and its leisure, and he definitely felt that he belonged.

One factor in the cultural pattern of many of the Ozark communities has been an outstanding respect for a father's unlimited right to bring up his children as he sees fit. This attitude is reflected in the infrequency with which a child is brought into juvenile court. Although children in the small towns are doing many of the things that bring their city cousins before the judge, the community believes that the behavior of the children is the family's business. This is even more apparent in cases of neglect. I have many times discussed with local officials or community leaders complaints of abuse or neglect of children, so serious that in other places they would have brought about immediate court action. The local officials would admit the evidence, agree that the children had no chance in their present environment, but, when it came to taking court action to protect the child against his own parents, they would stop short and shake their heads "Let's just let it go."

In other communities, usually described as less backward, I have met a different type of community pressure, one which is harder to contend with. It is sometimes called "orphans' home fever." "The Jones children should be sent to an orphans' home because their father drinks; the Green children, because their mother is immoral; the Collins children, because their home is too poor and dirty." It is this which makes the child-welfare worker wonder whether that reluctance on the part of the community in the hill counties to infringe on the rights of the parent does not have possibilities of strength. If their thinking could be guided so that they might maintain their respect for the strength of family ties but see the possibilities in helping individual families, through case-work service, to a higher level of care for their children, perhaps they would not need to repeat all the mistakes of other communities. Perhaps they could skip that dark chapter in the evolution of child-welfare work when it was thought that taking a child from the city slums to a rural foster home with fresh air and sunshine would solve all his problems.

What security is there for a child on an Ozark farm—a two-room cabin, seven children, rocky soil, backbreaking work, then a drought and no crops? But security is not entirely a matter of economics. When you stop to think about it, how often have you seen, among the farmers of the Ozark section, that panic all too frequent in a city relief office among applicants who are facing no work, no light, no gas, eviction, hunger? While there are, of course, Ozark farmers who are worried and anxious for the morrow, there are certainly a great many who shrug their shoulders and say, "We'll manage somehow," although it is a secret between them and the Deity how they do so. They have seen hard times come too many times to lose their sense of proportion in hysteria.

There is, of course, a difference between stagnation and contentment, between inactivity based on hopelessness and a philosophical acceptance of limitations. But is there not in the attitude which is the butt of jokes about the "hillbilly" an element of acceptance of life and of other persons as they are? Social workers may talk glibly about acceptance but may not be too sympathetic with an attitude that does not result in action. Occasionally, however, they recognize in an individual, perhaps a merchant at a crossroads store, a rural teacher who has lived in the hills for years, or one of those many persons who have come into the Ozarks from "outside" seeking peace and quiet, a philosophical acceptance of life and of human frailties, which constitutes strength. Perhaps workers would do well to weigh values more carefully before trying to push rural clients into that fast pace of competition and ambition, which in their own weaker or wiser moments they bemoan. Perhaps this, which has been considered one of the major problems in the Ozarks, has in it an element of value that should be recognized and respected rather than jerked out by the roots.

"Guest Children" From Europe and Their Care

Questions and Answers The United States Committee for the Care of European Children has issued a pamphlet, How Can I Help, Questions and Answers, dealing with 53 inquiries most frequently received in regard to applying for child evacues from European countries and the responsibilities involved in their care.

U. S. Committee for the Care of European Children, 215 Fourth Ave., New York, September 1940.

Children in Exile Geraldine Pederson Krag, M. D., is the author of a booklet, Children in Exile, issued by the Child Welfare League of America, at the request of the United States Committee for the Care of European Children, to give foster parents of children from other countries an understanding of the special difficulties with which they may have to deal. These involve conflict of ideas, hostilities, and loyalties and the results of these conflicts. Although written primarily for foster parents who have taken European children into their homes, the pamphlet has applicability for any foster parent.

Child Welfare League of America, 130 East Twenty-second St., New York, December 1940.

Family Case Work Services for Refugees The Family Welfare Association of America has published a booklet, Family Case Work Services for Refugees, to meet questions arising from the increased responsibilities of case-work agencies in connection with refugees from Europe. It contains articles by Joseph E. Beck, Florence Nesbitt, and Helen Wallerstein, with a foreword by Maurine La Barre.

Family Welfare Association of America, 122 East Twenty-second St., New York, 1941. 30 pp., 40 cents.

British Quaker Children To facilitate the reception of Quaker children from England by American Friends who are ready to guarantee their support, the American Friends Service Committee has issued Information Concerning the Placement and Care of British Quaker Children as Bulletin No. 1, in cooperation with the United States Committee for the Care of European Children. This outlines the procedure to be followed by Friends in America who wish to provide homes for English Quaker children through the plan of the committee.

American Friends Service Committee, 20 South Twelfth St., Philadelphia, July 1940.

People Without a Country A special section in the *Survey Graphic* for November 1940 contains a group of articles dealing with the successive waves of refugees from Europe (In Europe: Why, Where, Who—the Refugees? by John F. Rich); with their experiences in this country (In the United States: The Refugees Here, by Gerhart Saenger); and with possibilities for resettling refugees in China, Siberia, the Philippines, Palestine, Africa, Australia, Canada, Alaska, Mexico, South America, and Central America (Elsewhere: Atlas of Hope, by Bruno Lasker). It also contains a directory of national agencies in the United States dealing with refugee problems. Reprints of this section are available at 10 cents under the title "People Without a Country" from the Survey Associates, 112 East Nineteenth Street, New York.

BOOK NOTES

National Conference of Social Work The 59 papers included in this volume were selected from among those read at the annual meeting of the National Conference of Social Work in Grand Rapids, Mich., May 26–June 1, 1940. They reflect the background of conspicuous international events against which they were presented. Part 1 contains papers on Social Objectives in a Time of World Crisis; part 2, Areas of Social Work Concern; and part 3, Social Work Practice. (Proceedings of the National Conference of Social Work, Columbia University Press, New York, 1940. 736 pp. $3.)

National Conference of Jewish Social Welfare "A Record of Communal Trends and Developments" is the general title of the proceedings of the National Conference of Jewish Social Welfare, including joint sessions with the National Council for Jewish Education and the National Association of Jewish Center Executives at the annual sessions, Pittsburgh, Pa., May 21–26, 1940. The papers included in the published proceedings contained in the *Jewish Social Service Quarterly* for September 1940 (Vol. 17, No. 1) constitute only about half of the actual proceedings of the sessions.

National Congress of Parents and Teachers In explaining the convention theme, "And the pursuit of happiness," Mrs. J. K. Pettengill, president of the National Congress of Parents and Teachers, stated that "life" and "liberty" had been the subject of consideration at two previous conferences.

The proceedings of this, the forty-fourth annual convention, held in Omaha, Nebr., May 6–9, 1940, include addresses and panel discussions, national officers, and committee conferences, reports of national chairmen, special reports, reports of State presidents, and records and information. (Proceedings, Forty-fourth Annual Convention, National Congress of Parents and Teachers, 600 S. Michigan Blvd., Chicago, 1940. 372 pp.)

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THE STEPFATHER IN THE FAMILY, by Adele Stuart Meriam. University of Chicago Press, Chicago, 1940. 158 pp. $1. Processed.

In the editor's preface Sophonisba P. Breckinridge states that little attention has been given in legislation to the responsibility of a stepfather. It is hoped, therefore, that this study will bring out into clear relief differences between the judicial and the administrative attitude on this problem and clarify situations that should be dealt with in nonsupport laws having to do with the maintenance of young children.

Miss Meriam found that the stepfather is the "forgotten man" in the law library, having been given a place in the statutes of only 6 States. The principles found in the decisions of the State courts regarding the legal position of the stepfather form the major part of the study. One hundred and five cases are considered, covering 31 States and a period ranging from 1790 to 1939.

Chapter headings include: The problem of the stepfather; the stepfather as a stranger; the in loco parentis relationship; special features of the relationship between stepfather and stepchild; termination of an in loco parentis relationship; the stepfather as guardian; statutory provisions; the stepfather under the Social Security Act; conclusion. M. M.

• CHILD LABOR •
• YOUTH EMPLOYMENT •
• VOCATIONAL OPPORTUNITIES •

Progress in the Administration of State Child-Labor Laws

By Louise Q. Blodgett

Regional Consultant, Industrial Division, U. S. Children's Bureau

In the November–December 1940 issue of *The Child* there appeared a summary of the advances made in child-labor legislation in 1940. It may be interesting to hear about the experience of one State after the first 3 months under a new child-labor law.

New Jersey's law, which went into effect on September 1, 1940, contains detailed provision for the issuance of employment and age certificates by local school officials under the supervision of the State Department of Labor and the State Department of Public Instruction. The forms for the certificates and all necessary papers are furnished by the State Department of Public Instruction and distributed to the local issuing officers together with instructions for their use in accordance with the State child-labor law. The certificate form is printed in triplicate and the issuing officer is required to send a copy of every certificate issued to the State Department of Labor for examination. With the copy of the certificate must also be sent the papers upon which the certificate was granted; namely, the evidence of age, the promise of employment, the physician's certificate of physical fitness and, when required, the school record. In addition to these provisions for State supervision, the law sets forth the exact procedure to be followed in issuing certificates for employment. Thus, by providing for a good certification system, the law assured at the outset one effective method of enforcement which could be put into immediate operation.

The new law got off to an excellent start when the State Department of Public Instruction printed new certificate forms and instructions and had these in the hands of the issuing officers before the law actually became effective. The Bureau for Women and Children of the State Department of Labor was ready to examine the duplicate certificates and accompanying papers for compliance with standards set forth in the new law. Thus the way was prepared for adequate State supervision. New Jersey has 354 school districts authorized to issue certificates. The difficulty of instructing local school officials on proper issuance procedure under a new law and in accordance with uniform standards may easily be imagined. Since the appropriation for enforcement of the law by child-labor inspectors was not made until after the act had been in effect for nearly 4 months, the enforcement during these early months was largely dependent upon the certification system.

An analysis of the duplicate certificates which came to the Bureau for Women and Children in the State Department of Labor shows that about 11,000 employment and age certificates were issued by local school officials from September 1 to December 1, 1940, and that 917 of these certificates contained irregularities showing that they had not been issued in accordance with the child-labor law.[1] After all certificates and accompanying papers were carefully examined in the office of the Bureau for Women and Children these 917 certificates were returned to the issuing officers as unapproved, with instructions that certain certificates issued contrary to the new law should be canceled, and that others should be corrected or followed up for more complete information. Thus it was possible, through careful administration of the certification provisions, to make a prompt check-up on compliance with the new child-labor law, for more than 11,000 minors who applied for certificates for employment.

A further advantage gained by having such a system of State supervision whereby certificates are approved or rejected in the State office is that it makes possible a uniform interpretation of the State law, with the Attorney General's office readily available for rulings on difficult points and one central authority to whom employers, the public, and issuing officers can turn for information.

The Department of Public Instruction at the outset of the program called conferences in several industrial counties for issuing officers, members of State and local chambers of commerce, personnel managers of industrial concerns, and other interested persons. At these meetings the provisions of the law were discussed and questions were answered. The Bureau for Women and Children of the State Department of Labor has continued this educational work in connection with the new law in all parts of the State, through its correspondence with local issuing officers in regard to the irregularities found on the certificates.

The certification system is an effective means of forestalling illegal employment of minors who apply to the issuing office for certificates, but completely effective administration of any child-labor law is possible only when the two strong arms of the enforcement machinery—certification and inspection—function equally well. Since the substantial appropriation for the remainder of the fiscal year was made to the State Department of Labor for the enforcement of the child-labor law, inspectors have been appointed and are being trained for work in the field, looking especially to the possible trouble spots in street trades and agriculture. It is hoped, therefore, that a thorough drive for compliance will soon be under way.

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[1] Reports submitted by the Bureau for Women and Children of the New Jersey State Department of Labor.

Fair Labor Standards Act Held Constitutional

The United States Supreme Court, on February 3, 1941, upheld by a unanimous decision the constitutionality of the Federal Fair Labor Standards Act of 1938.

The case (*United States of America* v. *F. W. Darby Lumber Co. and Fred W. Darby*) arose upon the prosecution by the Government of the F. W. Darby Lumber Co. for violation of the wage and hour standards of the law. The defendants challenged the validity of the act under the Commerce Clause and the Fifth and Tenth Amendments to the Constitution. The lower court had declared that manufacture is not interstate commerce and that the regulation by the Fair Labor Standards Act of wages and hours of employment of those engaged in the manufacture of goods which will be sold in interstate commerce is not within the congressional power to regulate interstate commerce. The Supreme Court reversed the finding of the lower court, holding that restrictions of the Fair Labor Standards Act are well within the field of congressional control under the Commerce Clause.

In reaching its conclusion the Court specifically overruled the case of *Hammer* v. *Dagenhart* (247 U. S. 251), which had declared unconstitutional the first Federal child-labor law, passed in 1916, as beyond the power of Congress to regulate interstate commerce.

Technical Advisory Committees

The Technical Advisory Committees for the Children's Bureau on the Hazards of Logging and Sawmilling and on the Hazards of Woodworking-Machine Employments met during February to discuss the findings of the Bureau's preliminary investigations in these fields and the drafting of orders for issuance under the Fair Labor Standards Act applying the 18-year minimum-age standard.

These two committees have been divided into eastern and western sections as the Western States are a very important producing area for lumber and lumber products. The western section of the Technical Advisory Committee on Hazards of Logging and Sawmilling met in Portland, Oreg., on February 4, 1941, and the eastern section of the committee met in Washington, D. C., on December 13, 1940. The western section of the Technical Advisory Committee on Woodworking-Machine Employments met in Portland on February 5 and the eastern section of this committee, in Washington on February 18.

Defense and Vocational Guidance

A joint conference on defense and vocational guidance met in Washington, D. C., November 8 and 9 at the call of Harry A. Jager, Chief, Occupational Information and Guidance Service, United States Office of Education, and Mary P. Corre, president, National Vocational Guidance Association. Some 50 persons participated in the conference for the purpose of outlining constructive ways in which vocational guidance may be of service in the present situation.

As reported by Ralph B. Kenney in *Occupations* for January 1941 (Vol. 19, No. 4) under the title, "Our Share in National Defense—the Washington Conference," the delegates voted that a committee be appointed to explore the broad areas discussed and to formulate recommendations. The areas that the committee is directed to explore are given as follows:

1. How can the vocational-guidance services of the secondary schools of the country be of greatest assistance in this emergency, and what special helps and materials will they need?
2. How should the curriculum better reflect the needs of the community (shown by community occupational surveys) and the needs of students (shown by follow-up studies)? At the same time how may an overemphasis on a narrow type of vocational training be prevented by an awareness of the need for continued educational opportunities?
3. How may maximum cooperation be secured among the many community agencies, e. g., schools, public employment service, and so forth?
4. How can communities provide the necessary number of vocational counselors?
5. How may the best services of all groups be utilized, including women and girls? such minority groups as Negroes, and others?
6. What constructive activities may communities now be encouraged to initiate to help lessen the severity of the problems that may arise when this period of heightened industrial activity has ended?
7. How can occupational information related to defense industries be made available for classes in occupations and counseling in the school?

"Raising a President" Begins Second Series

Children in migrant families, sharecropper families, in families in defense areas, children in the North, South, East, and West of the United States will share the spotlight in the second series of the radio program, "Raising a President," presented by the Children's Bureau.

The first 13 programs, which began in October 1940, were concerned with various aspects of food and nutrition. The second series, planned for greater variety and wider scope, began on January 29 and will be heard each Wednesday until April 30 over the blue network, National Broadcasting Co., at 2 p. m., Eastern standard time.

BOOK NOTES

Publications of Government Agencies

Labor legislation The following publications in the field of labor legislation have been issued by the Division of Labor Standards of the United States Department of Labor:

HANDBOOK OF FEDERAL LABOR LEGISLATION. Bulletin No. 39, Part 1, Washington, 1940. 86 pp. This handbook is intended to supply information for workers, union representatives, and Government agencies as to labor standards on Government contract work and work financed by the United States. Prepared in looseleaf form, it is arranged by statutes, giving the labor provisions of each law and the Government agency charged with administration. Other parts will deal with the Wagner Labor Relations Act, the Fair Labor Standards Act, and the Railway Labor Act.

DIGEST OF STATE AND FEDERAL LABOR LEGISLATION ENACTED JULY 1, 1939, TO JULY 1, 1940. Bulletin No. 40, Washington, 1940. 14 pp. Labor laws enacted by the Seventy-sixth Congress and the eight State legislatures that met in regular session are included.

RECENT PROGRESS IN STATE LABOR LEGISLATION. Bulletin No. 42, Washington, 1940. 30 pp. This pamphlet presents the report of the Secretary of Labor to the Seventh National Conference on Labor Legislation, which met in Washington, December 9–11, 1940.

REPORTS OF COMMITTEES AND RESOLUTIONS ADOPTED BY SEVENTH NATIONAL CONFERENCE ON LABOR LEGISLATION, DECEMBER 9, 10, AND 11, 1940. Bulletin No. 45–A, 1941. 26 pp.

National defense Publications bearing on national defense issued by the United States Department of Labor include the following:

WORKERS AND NATIONAL DEFENSE. U. S. Department of Labor, Washington, 1940. 15 pp. This is a leaflet for popular distribution explaining the national-defense program.

CONSERVING MANPOWER IN DEFENSE INDUSTRIES. Division of Labor Standards Special Bulletin No. 4, Washington, 1940. 7 pp. A plan for pooling safety services is outlined in this folder by the National Committee for the Conservation of Manpower in Defense Industries.

OUT OF CRISIS, OPPORTUNITY; APPRENTICESHIP IN A LONG-RANGE DEFENSE PROGRAM. Federal Committee on Apprenticeship, Washington, 1940. 27 pp. This bulletin outlines procedures for starting apprenticeship programs, suggests training standards, and offers the technical assistance of government in expanding apprentice training.

Department of Agriculture Of special interest in connection with rural and village problems and conditions are the following publications of the United States Department of Agriculture:

THE OUTLOOK FOR FARM FAMILY LIVING IN 1941. U. S. Department of Agriculture, Bureau of Home Economics, Washington, October 1940. 45 pp. Mimeographed. This report was prepared for the Agricultural and Farm Family Living Outlook Conference.

1941 AGRICULTURAL OUTLOOK CHARTS. U. S. Department of Agriculture, Bureau of Home Economics and Agricultural Economics, Washington, 1940. 33 pp. Processed.

FAMILY INCOME AND EXPENDITURES, by Dorothy Brady, Day Monroe, Gertrude Schmidt Weiss, and Thelma Dreis. U. S. Department of Agriculture Miscellaneous Publication No. 375, Washington, 1940. 389 pp. This publication was prepared by members of the staff of the Bureau of Home Economics in cooperation with the Work Projects Administration. It is part 1 of a series of consumer-purchases studies in small city and village families and covers only the southeastern region of the United States.

WPA reports From the Work Projects Administration have been received a number of reports most of which are concerned with employment and unemployment problems of low-paid workers:

FAMILY UNEMPLOYMENT; AN ANALYSIS OF UNEMPLOYMENT IN TERMS OF FAMILY UNITS, by Don D. Humphrey. Work Projects Administration, Washington, 1940. 144 pp. The significance of individual unemployment is analyzed here in terms of family organization.

THE PLANTATION SOUTH 1934–1937, by William C. Holley, Ellen Winston, and T. J. Woofter, Jr. Work Projects Administration Research Monograph 22, Washington, 1940. 124 pp. This monograph points out the rapid changes in plantation organization and operation which have taken place in the southeastern part of the United States in the years covered by the study.

THE PLANTATION SOUTH TODAY, by T. J. Woofter, Jr., and A. E. Fisher. Work Projects Administration Social Problems Series No. 5, Washington, 1940. 27 pp. A less technical presentation of the material in The Plantation South 1934–1937.

THE PECAN SHELLERS OF SAN ANTONIO, by Selden C. Menefee and Orin C. Cassmore. Work Projects Administration, Washington, 1940. 82 pp. This is a discussion of the problem of underpaid and unemployed Mexican labor in the pecan industry of San Antonio.

Youth

THE YOUTH OF NEW YORK CITY, by Nettie Pauline McGill and Ellen Nathalie Matthews. Macmillan Co., New York, 1940. 420 pp. $3.50.

Interviews with more than 9,000 young New Yorkers, representing a 1-percent sample of the population of New York City 16 and under 25 years of age in 1935, formed the basis of this study, carried on by the staff of the Research Bureau of the Welfare Council of New York City with the assistance of State and city work-relief authorities and the Works Progress Administration. The study covers the educational and employment status and history and the educational, vocational, and avocational activities and interests of these young people, the emphasis being on normal youth in normal life situations. Many of the findings have been published separately, but the sections on the leisure-time interests of young people appear for the first time in this volume.

Fifteen percent of the youth were living in households that were receiving relief; the head of the family was employed in three-fifths of the parental homes in which youth lived; and only one-half of the young people who wished work were actually employed.

Of the 16- and 17-year-olds about 64 percent were in school, 9 percent were employed, and 23 percent were looking for work.

The report points out that:

> Young workers have not been getting their proportionate share even of such jobs as have been available. Moreover, unable to get experience without work, unable to get work without experience, youth has a unique class of potential unemployables. All kinds and all types of young workers have been affected. Once so certain of a place in the economic system, many high-school and college graduates are finding it impossible to get a foothold.

In regard to the use of leisure time it was found that most of these city youth, especially after they leave school, spend their leisure largely in the narrow routine of reading newspapers and magazines, listening to the radio, and going to motion pictures. Greater opportunities for organized games and athletics, for swimming, camping, and dancing were among the most frequently expressed wants. The report concludes with this paragraph:

> Perhaps more than anything else, if more abundant life for all youth is to receive the support of public opinion, youth needs to have kept before the community the fact that almost all wholesome and constructive recreation is now out of reach of all except the few.

• EVENTS OF CURRENT INTEREST •

New Publications Available From the Children's Bureau

CHILD-WELFARE SERVICES UNDER THE SOCIAL SECURITY ACT is a bulletin of 82 pages covering the development of the program for child-welfare services in the years 1936–38. In addition to a general review of accomplishments and reports on current reporting on child-welfare services and on the training of workers it contains a brief summary of the program in each State. (Bureau Publication No. 257. Washington, 1940.)

GRANTS TO STATES FOR MATERNAL AND CHILD WELFARE (Maternal and Child Welfare Bulletin No. 1) has been revised on the basis of the Social Security Act amendments of 1939. The revised edition (Bureau Publication No. 253, Washington, 1940) gives the apportionment of funds for the fiscal year 1941 to the States for maternal and child-health services, services for crippled children, and child-welfare services, and a list of State agencies administering these services as of August 1, 1940.

Five reprints from the *Annals* of the American Academy of Political and Social Science for November 1940 are available from the Children's Bureau while the supply lasts:

CHILD WELFARE, 1930–40, by Katharine F. Lenroot.

FOUR MILESTONES OF PROGRESS, by Homer Folks.

PROGRESS IN SAVING MATERNAL AND CHILD LIFE, by Richard Arthur Bolt.

CHANGING CARE OF CHILDREN BORN OUT OF WEDLOCK, by Agnes K. Hanna.

CHILD WELFARE WORK IN RURAL COMMUNITIES, by Mary Irene Atkinson.

Two separates from the Preliminary Statements Submitted to the White House Conference on Children in a Democracy, January 18–20, 1940, Washington, D. C., have been issued and can be obtained from the Children's Bureau on request. These are:

HEALTH AND MEDICAL CARE FOR CHILDREN.
SOCIAL SERVICES FOR CHILDREN.

Single copies of the following reprints from current periodicals are obtainable from the Children's Bureau while the supply lasts:

STANDARDS FOR CARE OF NEWBORN AND PREMATURE INFANTS IN HOSPITALS, by Marion M. Crane, M. D. *Hospitals*, December 1940.

VITAMIN K IN OBSTETRICS; A REVIEW OF ONE YEAR'S EXPERIENCE, by L. M. Hellman, L. B. Shettles, and N. J. Eastman. *American Journal of Obstetrics and Gynecology*, Vol. 40, No. 5 (November 1940).

CHILD WELFARE SERVICES—OUR FIRST LINE OF DEFENSE. *Social Service Review*, Vol. 14, No. 4 (December 1940).

Additional folders now available for distribution in the series issued in connection with the Children's Bureau series of radio programs, Raising a President, are as follows:

YOUR CHILD'S SLEEP. Folder 11.

YOUR CHILDREN'S FOOD AND THE FAMILY POCKETBOOK. Folder 24.

SUBSTITUTES FOR THE SUN. Folder 25.

Also available from the Children's Bureau is Eat the Right Food To Help Keep You Fit, a folder issued by the Bureau of Home Economics, United States Department of Agriculture, with the cooperation of the Children's Bureau, United States Department of Labor, and the Office of Education and the Public Health Service, Federal Security Agency.

University of North Carolina Gives Course for South Americans

A group of 85 students, teachers, and professional men and women from Chile, Peru, Ecuador, and Colombia arrived in New York, Monday, January 13, 1941, to attend the special winter session of the University of North Carolina, organized for South Americans. This is the first time that an American university has arranged for a 6-week session devoted to courses and work of specific interest to persons from the other American Republics.

This large group includes university students, professors, architects, physicians, lawyers, literary men, and statesmen.

(*Official statement of Department of State.*)

CONFERENCE CALENDAR

Mar. 27–29	American Academy of Pediatrics. Meeting of Region 1, New Haven, Conn.
Mar. 28–29	American Association for Social Security. New York, N. Y.
Mar 31–Apr. 1	American Eugenics Society. Fifteenth annual meeting, New York, N. Y. Information: Rudolf C. Bertheau, Secretary, RKO Building, Rockefeller Center, New York.
Apr. 4–5	American Academy of Political and Social Science. Philadelphia, Pa.
Apr. 8–10	Conference on the Conservation of Marriage and the Family. Seventh annual conference, University of North Carolina and Duke University.
Apr. 16–19	National Association of Housing Officials. Cincinnati, Ohio.
Apr. 17–19	Child Welfare League of America. Midwest regional conference, Chicago, Ill.
Apr. 21–25	American College of Physicians. Twenty-fifth annual session, Boston, Mass.
Apr. 29	Conference of State and Territorial Health Officers with the United States Public Health Service, Washington, D. C.
Apr. 30	Conference of State and Territorial Health Officers with the Children's Bureau, Washington, D. C.
Apr. 30–May 3	National Education Association. Department of Health, Physical Education, and Recreation. Atlantic City, N. J.
May 5–8	National Tuberculosis Association. Annual meeting, San Antonio, Tex.
May 5–9	American Association of University Women. National biennial convention, Cincinnati, Ohio.
May 11–14	American Society of Planning Officials. National conference on planning, Philadelphia, Pa.
May 19–22	National Congress of Parents and Teachers. National convention, Boston, Mass.
May 19–24	General Federation of Women's Clubs. Golden jubilee triennial convention, Atlantic City, N. J.
May 22–24	American Pediatric Society. Hot Springs, Va.
May 29–31	National Probation Association. Annual conference, Boston, Mass.
May 30–31	American Heart Association. Scientific meeting, Cleveland, Ohio.
May 30–31	American Association of Social Workers. Delegate conference, Atlantic City, N. J.
May 31–June 1	Community Chests and Councils, Inc. Atlantic City, N. J.
June 1–7	National Conference of Social Work. Sixty-eighth annual session, Atlantic City, N. J.

the CHILD

Monthly Bulletin

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

MARCH 1941

THE CHILD

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Measures for Protection of Newborn Infants

Instituted at the Long Island College Hospital

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"MY BABY was born into the world without an infection. It was your duty and the duty of your institution to protect him from infection." So says the average mother of a newborn infant when she learns that her child is suffering from some infectious disease. The mother's criticism is likely to be sound, even allowing for the fact that infants sometimes are born with an infection, as every one knows who has had anything to do with their care and management. However, she cannot fairly demand absolute protection until medical knowledge is more complete and until she and her family cooperate more fully in the application of what is known. This cooperation will be forthcoming if she has some understanding of the underlying difficulties. In this article I shall discuss some of these difficulties and describe the medical measures which we have instituted to meet them at the Long Island College Hospital.

Because the newborn infant is particularly susceptible to certain types of infection, special precautions must be taken for his protection as well as for that of his companions in the nursery.

The public has become familiar with the fact that epidemics can and do occur in nurseries for newborn infants, even in elaborately equipped hospitals of highest professional standing. Most publicized among the conditions that cause such epidemics is the dread diarrhea of the newborn. This disease sometimes carries a mortality rate as high as 80 percent and taxes to the utmost the resources of the most expert pediatricians. Because exhaustive researches have not disclosed its cause or the means of its transmission, its control is exceedingly difficult even under ideal medical conditions. The only effective weapon in combating this scourge of modern nurseries is a meticulous isolation technique rigidly applied to infants who have sickened of the disease or have been exposed to it.

Far more important, though usually less dramatic, are infections of the skin, infections of the respiratory tract, and infections of the eyelids and the eyes themselves. It can be said with pride that the measures taken by obstetricians and pediatricians against syphilis and gonorrhea are so effective that these infections are rarely met in average nursery practice in an active or menacing form. Only one case of gonorrheal ophthalmia has occurred among the newborn infants of the Long Island College Hospital during the past 20 years although many of their mothers had gonorrhea. On the contrary, skin and respiratory infections have not been rare; they tend to spread rapidly from patient to patient and may become generalized in any affected infant. Such a generalized infection is known as sepsis. Although chemotherapy and serum therapy have greatly simplified the control of certain types of generalized infections, other types resist all forms of treatment and almost invariably end fatally. As a consequence, the physicians in attendance and the nurses alike have a wholesome horror of these conditions and the circumstances that lead to their development.

Factors in Spreading Infection

The circumstances that favor the development of the common types of nursery infections are:

1. Unnecessary contact with visitors, nurses, and physicians.
2. Inadequate isolation of the infants from one another in the nursery.
3. Faulty technique for preventing the spread of contamination through—
    (*a*) Unsatisfactory nursing assignments.
    (*b*) Common bathing and common weighing facilities.
    (*c*) Inadequate facilities for sterilization of bottles, milk mixtures, and other materials used in the care of the infants.
    (*d*) The common utility room.
    (*e*) The proximity to uncontaminated units of isolation units.

1. Unnecessary contacts, especially with visitors, are an important source of infection. In practically every community in this country the causative agents of epidemic diarrhea of the newborn and of skin and respiratory diseases are present and may be introduced into the maternity and nursery units by the mother or her visitors at almost any time. Unfortunately, visitors are a menace of the first magnitude from the point of view of persons attempting to control infection. Yet in some hospitals no restriction is placed on the number of visiting hours or on the number of visitors. It is not unusual for visitors to come to the mother's bedside in uncovered street clothes, and sometimes visitors with severe colds or visible skin lesions are admitted. Frequently there is no age limitation for visitors to the mother, and children, who are the most frequent hosts and carriers of infection, are permitted to have contacts with the mother and so become a potential menace to the maternity and nursery units.

To examine nurses carefully and exclude from the nursery any who are found to harbor infection is an elementary precaution that is not universally observed. In many institutions nurses do not wear masks and gowns while caring for infants. Requirements for physicians are subject to precisely the same criticism.

2. Inadequate isolation of the infants from one another is also a possible means of spreading infection. It is common practice to have large nurseries where in certain instances more than 30 infants are quartered in a single room. They may be but a few inches apart, and even if they are farther apart their presence in a single large room gives maximum opportunity for the spread of all types of infection to this large group. This is particularly true of respiratory infections which are spread by the exhalation of droplets.

3. A third means of spreading infection is its transmission through some intermediary.

(*a*) The primary factor in this spread is the time-honored practice of the blanket assignment of nurses who are on duty in nurseries. That is, a nurse is assigned to certain general tasks, such as the bathing or feeding of a large group of infants, or to the administration of medication to the entire group. The alternative is the assignment of the entire care of a small group of infants to an individual nurse. It is at once clear that each nurse who has a general assignment will have contact with all the babies in a unit, whether the unit is large or small, and if infection is present, will carry it to all the infants with whom she has contact.

(*b*) Another important item is the common bathing and weighing room. Usually there is but one room for this service in each nursery, and if two nurseries adjoin each other such a room may be used for both nurseries. In any case, every baby in either one or two large units is taken to a central place which becomes contaminated if and when infection attacks any infant or infants in the group. With such a setup it is inevitable that there should be widespread transmission of infection when it occurs.

(*c*) Similarly infections spread because of inadequate facilities for sterilization. The usual practice has been to locate the formula room for the preparation of fluids, milk mixtures, and materials of all sorts for infants on the same floor as the nurseries. The average formula room is a single room to which utensils are usually returned without sterilization after their use by patients. Naturally, the entire formula room may be contaminated if any infant in any nursery served from it has become infected. The precautions which heretofore have been relied on as effective are these: Bottles, nipples, and utensils are washed and sterilized in the formula room. Once the sterilization step has been completed, the room is usually washed with soap and water and the persons who are to prepare the mixtures thereupon follow a technique that is surgically correct in preparation of the milk mixtures and materials. These precautions are worthless, however, for any contamination which has been introduced at any time is still present and contaminates the mixtures under preparation, and eventually the infants to whom they are given. Furthermore, milk and other foodstuffs are taken into the formula room without special handling designed to avoid the introduction of contamination from outside.

(*d*) Of particular interest is the common utility room: This ancient institution is even more dangerous as a means of spreading infection than the common bathing and weighing room. Such a room usually is located on the same floor as the nurseries and used as a storage room for milk mixtures and other materials needed in the nurseries. Before the feedings are given to the infants the bottles are warmed and the nipples adjusted in this room. Nurses who use the facilities of the utility room come from every unit on the floor, including sometimes the units for the isolation of infected infants and those suspected of infection. It is obvious that any contamination which is brought to the utility room from any source must inevitably be widely distributed by all who use this room.

(*e*) Another menace is the proximity of isolation units to uncontaminated units: It is common practice to locate isolation nurseries on the same floor as the uncontaminated nurseries or even to make these isolation facilities an integral part of the uncontaminated nursery set-up. Only a perfect isolation technique such as is used in the best-managed hospitals for infectious disease can possibly afford protection when such a set-up obtains. This perfect technique is rarely employed in maternity hospitals.

Corrective Measures Suggested

In the hope and expectation that we could correct many of the defects just noted, we have made extensive changes in the nurseries at the Long Island College Hospital in Brooklyn. The service in which these changes have taken place is located in a general hospital in Brooklyn which cares for some 1,500 newborn infants annually. Before these alterations were made, the routine was similar to that used in first-class teaching hospitals. While our results have compared favorably with the best so obtained, these results were not satisfactory in our opinion. When infection occurred, its spread could not always be limited by the application of the familiar methods of management. After careful study we decided on extensive changes in the set-up. These consisted of a rearrangement of the nurseries, radical changes in the formula room, and alteration in the nursery routine which included both changes in medical technique and a reorganization of the entire personnel caring for newborn infants.

The discussion of the corrective measures will follow the same order as did the discussion of the defects. First, then, is the consideration of the limitation of unnecessary contacts with visitors, nurses, and physicians.

1. (*a*) Visiting hours for ward patients have been limited to 5 hours a week. The visitors are masked and gowned and by means of rope barriers are separated from the beds in each public ward so that they are least able to contaminate the mothers or their bed units. It is admittedly a concession to popular opinion that visiting hours are as many as they are and are conducted at all, even under these conditions.

(*b*) Nurses are required to wear masks and gowns at all times while caring for infants in the nursery. Routine throat cultures are made on nurses who are about to come on duty in the nurseries. If dangerous organisms are found, the nurse is relieved of her duties. Complete studies are made to determine whether her infection is in any way a menace to the infants who have been under her care. If so, the nursery affected is quarantined, and the infants in it are treated as indicated by the studies made.

(*c*) A physician must wear mask, gown, and sterile gloves on entrance to any nursery for newborn infants. He must examine the infant in the special examining room attached to every unit unless there is an emergency which takes him into the nursery proper. If the physician passes from one unit to another, he must change his mask, gown, and gloves for every unit entered. House officers are assigned to individual nursery units and are not shifted unless they are ill or terminate their service in the nursery. If they become ill, they are relieved of their duties and are studied to ascertain whether their illness will in any way affect the infants who have been under their care. If so, the nursery affected is quarantined, and the infants in it are treated accordingly.

(*d*) Ward maids and cleaning women in the nurseries are subject to the same regulations as nurses and physicians, and are rigidly supervised by both.

(*e*) Every nursery unit has in its examination room complete medical equipment so that no contamination can occur by way of stethoscopes, otoscopes, or other instruments that might be brought in by the attending or house staffs.

(*f*) All bedclothing, diapers, and clothes for the infants in the nurseries are sterilized by autoclave. Each infant's supply for the day is stored on a shelf under his crib. Thus only his own nurse comes in contact with his supplies. A further most practical refinement is the sterile packet, devised by our nursing staff for the infant at bath time. This packet contains sterile cotton balls for laving the infant's eyes with normal saline solution, a sterile shirt, diaper, and dress, and a sheet and blanket for the infant's bed. This is in sharp contrast with the usual practice of having a central supply room.

2. We have made our nursery units as small as the physical plant would permit. As can be seen from figure 1, each main unit consists of a room containing 16 cribs, an adjoining but separate room for weighing and bathing, and an examining room partitioned off for the use of physicians. (Although it will be mentioned again in a later section, it should be observed that each unit has a refrigerator for the storage of milk mixtures, a bottle warmer, a sterilizer, and a scrub sink.)

The cribs in each unit are arranged in two groups of eight and are never interchanged.

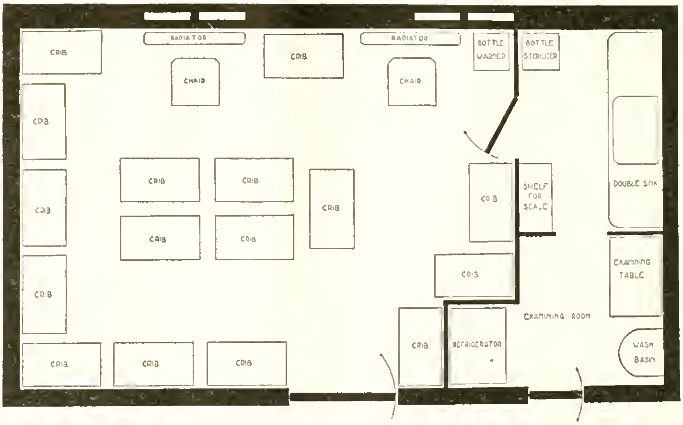

Figure 1.—NURSERY FOR NEWBORN INFANTS, ONE OF THREE TYPICAL UNITS.

Long Island College Hospital, Brooklyn, N. Y.

The cribs are separated from one another by at least 6 inches.

This physical set-up, combined with a technique which will be described later, affords excellent protection against the spread of all except respiratory infections. Only ultraviolet radiation and air-conditioning, as yet beyond our means, could provide this protection.

For the care of premature infants, we employ completely air-conditioned incubators of the Chapple type. This permits them to be cared for inexpensively in the same units as are full-term infants and with the greatest possible protection against infection.

3. The measures taken to prevent the spread of infection from infant to infant through an intermediary are as follows:

(*a*) The assignment of nurses caring for newborn infants has been changed so that 1 nurse cares for but 8 babies—7 full-term and 1 premature. The nurse is assigned for complete care of these infants. That is, the nurse takes them to their mothers to nurse or gives them their milk mixtures or fluids; she bathes them, weighs them, and cares for them in every particular. This personal, individualized service permits the nurses to know in detail the condition of the mothers and babies in their charge. If they follow the required technique, they cannot transmit any infection beyond their group of 8 babies, much less beyond the ward of 16 in which they function. This is one of the greatest improvements we have made and is, we believe, unique.

(*b*) Complete bathing and weighing facilities are provided for every individual unit of 16 infants. Ideally such facilities should be limited to units of 8. As this was not practicable, a routine has been instituted which reduces as much as possible the harmful effects of this limitation in physical plant.

(*c*) A formula room has been devised in which sterile milk mixtures and other materials are prepared, and we have provided a set-up in each unit to keep these materials sterile until they are given to the infants. We have, likewise, installed facilities for the sterilization of used bottles, nipples, and utensils before they leave any unit, so that no incipient infection may be carried by them to the formula room or to any other unit in the hospital.

The formula room is in a section of the hospital entirely removed from the nurseries. Ideally, we believe it should adjoin the unit in the clean surgical division where sterile solutions and similar materials are prepared. We hope to attain this goal when proposed physical changes in the hospital are undertaken. The formula room is so arranged that contamination from outside the hospital or from any unit in the hospital is reduced to the minimum.

All materials and utensils that enter the formula room pass through the sterilizer, which extends through the wall between it and the anteroom, or over the Dutch door (fig. 2). The sterilizer, of course, will destroy all contaminants. A special technique has been worked out to permit the use of the Dutch door and still avoid the introduction of contamination.

Once in the unit, these materials are made into milk mixtures according to formula, placed in sterile bottles, capped with sterile nipples, and covered with sterile glass caps. All of this is done by trained nurses in sterile gowns, masks, and gloves. These nurses are very carefully supervised and inspected and are relieved of duty immediately whenever they

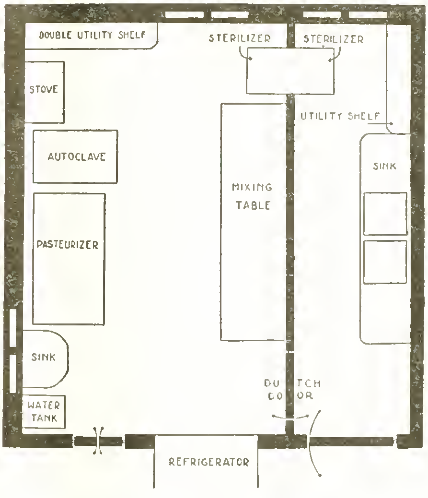

Figure 2.—FORMULA ROOM.

Long Island College Hospital, Brooklyn, N. Y.

are ill. Their throats are cultured at the beginning of their term of duty in the formula room and subsequently whenever indicated. Although all these precautions are taken before and during preparation of mixtures, it is nevertheless considered that there might be contamination by air, hands, and so forth. Therefore, the milk mixtures and other fluids are pasteurized at 140° to 160° F. for 30 minutes. Repeated cultures of mixtures so prepared have shown that they are sterile.

The anteroom where the bottles and materials are prepared to enter the formula room has special protection from outside infection. All the bottles, nipples, and utensils which return to this unit from any unit in the hospital, such as the nursery for newborn infants, the children's surgical ward, or the children's medical ward, are washed and sterilized in the unit where they are used before they come to the anteroom. They are cleansed and sterilized again in the anteroom before they are delivered to the formula room proper.

When milk mixtures have been completely prepared, the bottles are passed through a window in the formula room by the surgically clean nurse in attendance and are then transported in a closed cart, used exclusively for sterile milk mixtures, to the unit where they are to be used. Each unit has its own refrigerator to receive these mixtures and materials.

(*d*) A common utility room is not needed, because each unit has its bottle warmer, its sterilizer and scrub sink, and plenty of utensils. As all utensils are cleansed and sterilized before they leave the unit, no contamination can spread to other nursery units or to the formula room. The importance of these precautions can be appreciated if one considers what could happen in their absence should an infant in any unit sicken with bacillary dysentery. Although this is a rare disease in newborn infants, it did occur in another metropolitan hospital, with fatal consequences to a large number of infants. The probable sequence would be that the infected infant, whose infection might be unrecognizable for some time, would contaminate his nursing bottle and nipple from which he might have received boiled water or a milk mixture. These utensils would be taken to the common utility room where they would be cleansed but not sterilized and would be returned to a formula room to contaminate it. From any of these points of contact any one might acquire the disease. Our set-up is planned to eliminate this possibility. As the bottles or other utensils are cleansed and sterilized in each unit only those infants in immediate contact with the sick or potentially sick infants would be in jeopardy.

(*e*) Proper isolation units are provided both for observation of suspected cases and for infants who are known to have transmissible disease. The intermediary isolation unit of eight cribs is located across the hall from the clean nurseries and is completely separated from them. It is equipped in the same way as the larger nurseries (fig. 3). Infants who are suspected of harboring transmissible diseases are observed there until discharged from the hospital. If they prove to have a transmissible disease, they are isolated in the true isolation unit which is completely removed from the nursery set-up; i. e., in another part of the hospital. When infants have had ritual circumcision during which they have been exposed to possible infection from numerous adults, they are transferred to this intermediary isolation unit until their discharge. When an infant is born of a mother who has recognizable respiratory disease, he is admitted to the intermediary isolation unit and is transferred to the completely isolated unit if he develops respiratory disease. The nursing and medical personnel and the equipment of the intermediary isolation unit are complete and independent of all uncontaminated units.

A private room entirely remote from the uncontaminated nursery has been equipped as a complete isolation unit. (When this room is not in use for the isolation of the infants, it earns income for the hospital as a private room.) In addition to the usual nursery equipment, it has a sterilizer, bottle warmer, and scrub sink. The milk mixtures for sick infants in this unit are stored in a refrigerator that has no contact with foods for other infants.

When infants are completely isolated, they are cared for by graduate nurses who care for no other patients. The isolated infants are cared for by a medical house officer who has no duties in the uncontaminated nurseries. Every one who functions in this unit does so under strict isolation precautions such as are carried out in hospitals for the care of patients with infectious diseases.

Therefore, if any infant in any unit develops infection the following steps are taken:

1. The affected infant is immediately isolated. For infections of any importance complete isolation is instituted at once.
2. The unit from which this infant came is closed to further admissions until the hospital physicians feel certain that no new cases will develop. The duration of this quarantine depends on the type of infection encountered.
3. The nursing and medical personnel of the unit involved observe the most meticulous aseptic technique and carefully observe every exposed infant for the development of symptoms.
4. When a contaminated nursery has been emptied, it is thoroughly washed with soap and water, aired, and reopened 24 hours after cleansing. All cribs and mattresses are specially treated.

A most helpful aid in tracing any possible contamination is the daily work sheet kept by each nurse who cares for eight infants. Kept in diary form, these sheets record every detail about every baby. They comprise a perfect record of all events which occur in each nursery. From them one may easily trace the passage of infection from individual to individual or from unit to unit, should it occur. If by any chance there were a carrier of infection among the personnel this fact might easily be established by the diary.

Since these changes were completed, in June 1939, the incidence of infection among newborn infants has been greatly reduced. Of more practical importance, because all infection cannot be kept out no matter how excellent facilities and technique may be, is the fact that cross infection has been remarkably curtailed.

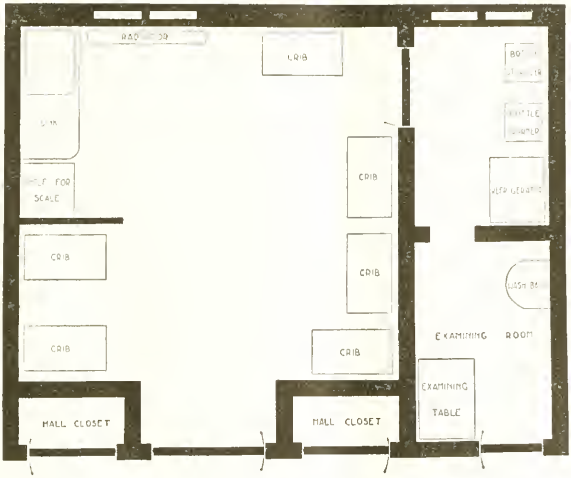

Figure 3.—NURSERY FOR NEWBORN INFANTS, INTERMEDIARY ISOLATION UNIT.

Long Island College Hospital, Brooklyn, N. Y.

The administration of a plan such as ours requires the eternal vigilance and cooperation of the obstetric, pediatric, and nursing departments. The results entirely justify this effort. The obstetric department has the responsibility for the mothers and their infants and makes the final decisions as to the disposition of personnel and transfer of infants. The pediatric department examines and cares for all the infants and makes recommendations to the obstetrician for his disposition if matters of administrative nature arise. There has been splendid cooperation by all departments and particularly by the nursing department whose load is the greatest, and the professional staff and hospital authorities alike are enthusiastic in their endorsement of the plan. The exacting requirements of the technique adopted have been faithfully carried out, and suggestions for further refinements are steadily forthcoming. This is due to a full appreciation of the soundness of the methods coupled with the experience that the actual work for every one has been diminished by these methods.

The physical changes were made inexpensively in a hospital of a design that permitted practically no flexibility in planning. The hospital authorities have expressed great satisfaction with their investment, because there has been so far practically no loss of service from quarantine and because there has been a sharp decline in the total cost of nursing and other service. Happily enough, the nursing and other services function better than ever before.

Far beyond these pecuniary considerations has been the effect on the medical staff and on the parents of infants born in the hospital. On both sides there is the firm conviction that the hospital has a proper organization for administration, a proper physical plant, and a sound technique, so that within the limits of present-day medical knowledge, these infants receive the best protection that can be given them.

Nursing the Premature Infant—A Cooperative Venture[1]

By Mary Emberton

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The word "venture" implies risk. The dictionary defines it thus, "to venture is to undertake in the hope of gaining a desirable result." In view of the fact that premature birth is given as the cause of more infant deaths than any other one condition, it can be seen how great a venture is the nursing of a premature infant. It seems important to point out some of the difficulties encountered in rural areas when a premature baby is born and to attempt to offer some suggestions as to how these difficulties may be met.

Good nursing care is perhaps the most important single point in any program for the care of premature infants, so the question arises immediately in the rural field how good nursing can be provided. Most farm families cannot afford even a few days of hospital care—to say nothing of weeks of expensive care necessitated by the hospitalization of a premature infant. All possible forces must be rallied to supply care for these babies in their homes—not just by the medical and nursing personnel but by everyone who could have a part in giving the baby a chance to live. That is why we refer to this care as a cooperative venture.

Let us look at what probably happens in a rural home when a premature baby is born. First comes a totally unexpected premature labor. Unless the mother has been instructed and helped in preparing supplies well in advance, many of the arrangements for the new baby are still incomplete. The woman who goes into labor prematurely is fortunate if she has the services of a nurse to assist the physician at the time of delivery. A good nurse can bring order out of chaos. She is the one who bustles the children off to the neighbors and sets grandmother, aunt, and father to performing useful tasks.

Unfortunately, too few rural mothers have the advantage of nursing care at time of delivery. The public-health nurse probably sees a premature infant for the first time several hours after he is born. Her value to this family will depend, first, on her ability to visualize needs so that she leaves her office equipped with necessities, and, second, her ability to utilize what she finds in the home. Every rural health department or nursing office should be equipped with some form of infant incubator. If one of these is available, the nurse should take it with her to the rural home. She should also take medicine droppers with rubber tips, oil, a measuring cup or bottle, cotton, and hot-water bottles. And, of course, she should have detailed instructions from the physician who delivered the mother.

She will find the members of the family trying to carry out instructions left by the physician about keeping the baby warm until the nurse arrives.

The public-health nurse knows that in this home she must try to work out a plan that will answer three vital questions:

1. How can *this* family keep *this* baby warm?
2. How can they protect him from infection?
3. How can they feed him the way he should be fed?

The most important consideration at first is how to keep the baby warm. As the premature baby's body temperature is easily influenced by his surroundings, it is important to maintain a constant temperature. The temperature of the room in which the baby is kept must be maintained between 75° and 80° F. day and night.

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[1] Paper read at the third annual meeting of the Louisiana Association of Public Health Workers, New Orleans, La., December 10, 1940.

How can this be managed? There probably is no type of home-nursing care that calls for the use of more good common sense than the nursing of the premature infant. Usually, the best place for this baby is *not* in the kitchen, but if the only stove is in the kitchen, then some plan must be worked out to give the baby privacy there. Two kitchen chairs put together in a corner with the box or basket bed placed on them can usually be managed. Care should be taken that the baby is not placed too near the stove, as there is danger in overheating. A thermometer should be hung near the baby's bed so that the temperature of the room can be watched carefully.

A rural nurse recently told how a father built a high, square table, on top of which he fastened a box in which the baby had his bed. The table was fastened to the floor. The mother could reach the baby to give him care, but he was completely out of reach of the small children in the family. This unit was placed in the corner of the kitchen. The ceiling was low, so it was much warmer for the baby there than it would have been nearer the draughty floor. An improvised screen provided further privacy. It will take cooperation of individual members of the family to see that the fire is kept up day and night, especially when wood or low-grade coal is used as fuel. Community cooperating agencies, such as the department of public welfare and the American Red Cross, may be asked to provide fuel if necessary.

If the home is sufficiently large to allow a heated room to be used for the premature baby alone, this would be the plan to follow.

Some provision must be made for keeping the baby's bed warm—about 80° to 90° F., depending on the size and vigor of the baby. If portable incubators are available, one of these may be used. However, sometimes families are awed by these devices and will not use them as intelligently as they would a simpler heating unit. A health officer in Colorado tells an amusing story that may illustrate this point. A portable incubator was set up in the home of a member of a sugar-beet "colony" of Spanish-Americans. The nurse spent a great deal of time making sure that the family understood the purpose of this heated box and its value to the premature infant. That afternoon the sanitarian from the county health unit had occasion to visit the colony and reported the residents lined up for a block waiting a chance to see the baby in the "baby house."

The simplest type of warm bed for a small baby is a basket lined with a cotton cloth or thin blanket. This is placed inside of a somewhat larger basket or box which is also lined with a blanket. Hot-water bottles or bags of hot salt or sand are placed between the two baskets. These are safer than hot bricks or flat irons because there is no danger that they will cause fire. Electric heating pads should not be used, either, because of danger of fire.

Clothing for the premature baby should be very soft and made so that it can be changed with the least possible handling of the baby. Nightgowns of flannel or stockinet and warm blankets spread loosely over the warmed bed are about all the baby will need if the bed is kept at proper temperature. For the first few weeks, small squares of absorbent cotton covered with soft gauze may be used to catch urine and feces.

Someone in the family must take primary responsibility for the baby. It usually is several weeks before the mother is able to do this, so the nurse must be sure that there is someone who fills this role. Grandmothers should not be shoved aside lightly in this situation, even though they may indulge in a few old-fashioned practices. Frequently, no one else has the patience that grandmother has. She is the one who will sit hour after hour by the bed and see that water bottles are kept warm; she will cut down clothing that is too large to fit the baby and will give him the watchful care he needs until the mother is able to assume responsibility. Of course, she will need guidance in how to keep the baby clean without much handling—bathing, oiling, and feeding him only as ordered by the physician.

The next consideration in the home is how to avoid infection. When there are crowded home conditions, this is very difficult. Sometimes it is possible to arrange that other children stay with neighbors or relatives until the premature infant has a good start in life. As it is almost impossible to keep preschool children in a home away from an infant, it may be desirable to arrange for their care elsewhere, in order to minimize the danger to the premature baby of colds, skin diseases, whooping cough, and other infections. Arranging for such a change in family life means cooperation on the part of a great many individuals. Church groups, lodges, and other community agencies have been known to help in such an emergency.

Rural people are neighborly. Sometimes they are too much so. It may take much explaining on the part of physician and nurse and real cooperation on the part of neighbors and relatives to see that unnecessary visitors are kept away from the premature infant.

The one who gives care to the infant must be sure she is free from infection, especially colds. She must be taught to wash her hands carefully before handling the child or any of his belongings. She must be taught how to boil all utensils used in feeding and how to keep them clean after boiling. It is a good idea to suggest that the father provide a little cupboard in which the baby's personal things may be kept. This may be made out of a packing box or orange crate if no other material is available.

How to feed the baby is the third major question for consideration. The best food, of course, is mother's milk. It will have to be supplied in a rural area probably by the baby's own mother. Whether or not the mother is able to supply this milk will be influenced by her physical and mental condition, her diet, daily sunshine and fresh air, and planned rest and recreation. Especially important is the manual expression of milk.

Helping the mother maintain her supply of breast milk is indeed a cooperative venture. The whole family will have to help to see that a well-balanced diet is supplied. Someone must go into detail as to what a well-balanced diet includes. This task often falls on the public-health nurse. If she is wise, she seeks aid from the home-demonstration agent and other workers in the field of nutrition in her area. Diet high in fluids and vitamin B is essential.

The husband and other members of the family can help in seeing that the mother has time for rest and recreation, so that she does not become overburdened with the care of the infant. Because a premature baby may be unable to take food, at times, and has a tendency to become cyanotic or to choke, his care takes a toll of the mother's emotional stamina as well as her physical strength. This emotional strain may prevent her from producing milk.

It will be necessary for the nurse to teach the mother manual expression of breast milk, including the care of her hands and of the milk after it is expressed. The expression of milk from the mother's breasts should be begun 12 hours after delivery; the colostrum—and the milk when it comes—should be given to the infant. Even if the baby is strong enough to nurse, manual expression should be employed to insure that the breast is completely emptied. If the baby is too weak to nurse the breast or to draw milk from a bottle with a small nipple, the mother's milk should be fed to the baby by means of a medicine dropper with a rubber tip. Care must be taken not to give the milk faster than the baby can swallow it. Care must be taken, too, that the baby is not overtired during feeding.

If mother's milk is not available, artificial feeding becomes necessary. The nurse will necessarily have to demonstrate, very carefully, the preparation of the formula ordered by the physician, and she must make sure that someone in the family knows exactly how to prepare and give the feedings. The same caution must be used when the time comes to give the baby cod-liver oil and orange juice.

It will be necessary for the nurse to keep a watchful eye on these premature babies, supplementing the physician's visits as necessary. The family needs constant guidance and encouragement.

No type of nursing care gives a greater degree of satisfaction to professional workers. There probably are few public-health nurses who cannot recall the thrill of joy experienced at some time when a premature baby showed enough strength to wriggle out of his first little padded jackets or to cry with a good lusty cry. How much more satisfaction a family must feel, the members of which have worked together for days and weeks in a cooperative venture which has given their baby a chance to live!

BOOK NOTES

YOUR CHILD'S DEVELOPMENT AND GUIDANCE TOLD IN PICTURES, by Lois Hayden Meek, Ph. D. J. B. Lippincott Co., New York, 1940. 166 pp. $2.

Dr. Meek has used both photographs and line drawings freely to portray the essential facts of the development of young children. There are 183 pictures. Some pages have pictures and text; others, pictures only. The pictures are so arranged that, as well as being decorative, they supplement and simplify the presentation.

The emphasis of the book is on the development of the baby rather than on the care of the baby. The first chapter is devoted to the physical development of the body and covers subjects such as posture, walking, height, weight, and body proportions. The fallacy of attempting to determine a child's physical fitness by comparing his weight and height with averages of children of his age is pointed out.

Other chapters deal with the development of patterns of eating, elimination, relaxation, rest, and sleep.

The social aspects of childhood are discussed in chapters devoted to relations with other children and being loved and loving.

The negative aspects of child development are discussed in three chapters dealing respectively with interferences and resistance, being afraid, and illness.

D. V. W.

THE DOCTOR AND THE DIFFICULT CHILD, by William Moodie, M. D. Commonwealth Fund, New York, 1940. 214 pp. $1.50.

Dr. Moodie is an English psychiatrist, at present medical director of the London Child Guidance Clinic and Training Center. This small book, in his own words, "is not a scientific treatise; it is rather an informal discussion of fundamental disturbances of behavior or personality in children and how they can be recognized, investigated, and treated."

The book is divided into two parts. In the first part recognition of problems, their investigation, and general methods of treatment are discussed. Dr. Moodie has laid down three conditions necessary for stable development—work and education, security, and affection—and has made the securing of these the first step in therapy. In the second part specific problems of behavior are presented such as stealing, lies, fancies and dreams, and feeding difficulties. No attempt is made at formal classification. Each problem is taken up in some detail and is illustrated by excerpts from case histories showing not only the problem but how it arose and how it was treated. These illustrations are not set apart but are woven into the text in an informal manner. Certain of the sections such as that dealing with nervousness, and the discussion of speech difficulties and crossed laterality should be particularly helpful to the general practitioner who is frequently confronted with such problems in his practice. In the section on backwardness, the distinction between the backward and the dull child is clarified for the lay reader.

K. B.

THROUGH CHILDREN'S EYES; TRUE STORIES OUT OF THE PRACTICE OF A CONSULTANT PSYCHOLOGIST, by Blanche C. Weill, Ed. D. Island Workshop Press, New York, 1940. 365 pp. $1.75.

Case histories of children who have found their way to the psychologist are used to show what kind of situation is likely to produce in children behavior which adults consider undesirable.

The book contains 38 case histories, each called by the name of the child described, and in almost every one the story is given from the child's point of view. Dr. Weill describes the child's behavior in such a way that the reader understands why the child needs to act as he does. Usually the story ends with a discussion of the general situation that led up to the behavior problem. In many cases the treatment used is discussed and the results described. In some cases the children were seen from time to time over a period of years; in others one visit is recorded.

D. V. W.

THE WONDER OF LIFE; HOW WE ARE BORN AND HOW WE GROW UP, by Milton I. Levine, M. D., and Jean H. Seligmann. Simon & Schuster, New York, 1940. 114 pp. $1.75.

The combined work of a physician and an educator, both of whom have had training in child psychology, is presented in this book on sex for the preadolescent and adolescent child. The book begins with an orientation to the whole field of biology. Spontaneous generation is discussed with descriptions of experiments proving that life comes only from life. The nature of living things is described and cells are shown to be the unit structure of life. Reproduction among all living things is discussed, first with a broad biological sweep, then with special reference to reproduction in mammals.

With this background the reader is led to chapters on the changes from girl to woman and from boy to man and a chapter on how human beings reproduce. Other chapters tell how the baby grows in the mother's body, how it is born, and how it is fed after birth. The book ends with chapters on twinning and the principles of family resemblances.

A glossary is included.

D. V. W.

A SURGEON EXPLAINS TO THE LAYMAN, by M. Benmosche, M. D. Simon & Schuster, New York, 1940. 317 pp. $3.

Surgical knowledge and procedure are translated in this book into the language of the layman.

There is a chapter on the tools of surgery which include anesthetics, instruments, and antiseptics, and a series of chapters describing the types of operations that everyday men and women are likely to require. The author describes the book as "a potpourri—a certain amount of surgery's strange history shows us how far we have progressed along the road of learning, a brief glimpse at the painstaking science of diagnosis tells us how we know what's wrong, and a simple description of surgical procedure tells us what to do about it."

The book is illustrated with numerous line drawings by Bhola D. Panth.

CARE OF POLIOMYELITIS, by Jessie L. Stevenson, R. N. Macmillan Co., New York, 1940. 230 pp. $2.50.

THE NURSING CARE OF PATIENTS WITH INFANTILE PARALYSIS, by Jessie L. Stevenson. National Foundation for Infantile Paralysis, 120 Broadway, New York, 1940. 58 pp.

The experience of the author from 1923 to 1939 as supervisor of the orthopedic division of the Visiting Nurse Association of Chicago is drawn upon in these two publications, which are designed to be of use to public-health nurses and other workers interested in adequate care for patients with poliomyelitis.

In the book, Care of Poliomyelitis, the author presents a brief history of the development of public interest in the disease and of the extent of the problem (ch. 1); discusses the etiology, the nature of the virus, mode of invasion of the virus, pathology, the course of the disease, and treatment during the acute stage (ch. 2); and considers convalescent care from the point of view of the public-health nurse and of the physical-therapy technician (chs. 3 and 4). Among the illustrations included in the chapters on convalescent care are those showing desirable positions for protecting muscles, and practical and inexpensive apparatus, both of which are adjuncts to better care for the patient. In the fifth and last chapter the author discusses a number of points important for those caring for patients who have had poliomyelitis. These include practical directions for teaching a patient to walk, to use crutches properly, and to sit down in and get up from a chair.

In the appendixes detailed descriptions and illustrations are given for making inexpensive appliances such as splints and corsets.

Much of the material in the pamphlet, The Nursing Care of Patients with Infantile Paralysis, is similar to that presented in the author's book. It is put in briefer form and is confined more strictly to the nursing aspects of the disease. The pamphlet contains line drawings showing apparatus and desirable positions for patients similar to those included in the book. There are in the pamphlet, however, a number of additional illustrations such as those demonstrating the turning of the frame patient.

In both publications the author, who is now consultant in orthopedic nursing, National Organization for Public Health Nursing, emphasizes the importance of teaching the patient and the family the principles underlying treatment in order that they may assume some responsibility for carrying out the techniques involved in home care. Both publications stress the significance of mental hygiene in relation to the care of the patient with poliomyelitis.

R. A. H.

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• CHILD WELFARE •

• SOCIAL SERVICES •

• CHILD GUIDANCE •

Rural Social Services for Negro Children

BY VINITA V. LEWIS

Special Consultant in Child Welfare, U. S. Children's Bureau

Child-welfare services for rural Negro children have been developed in a number of States with a large rural Negro population, under title 5, part 3, of the Social Security Act, which provides for services to children who are dependent, neglected, and in danger of becoming delinquent, in areas predominantly rural and areas of special need. In administering this section of the Social Security Act the Children's Bureau through its Child Welfare Division cooperates with the State public-welfare agencies. The funds available for extending and strengthening public social services for children have been used to demonstrate the value of case work for children and to strengthen State administrative facilities.

The program for child-welfare services, being primarily for rural areas, is applicable to rural Negro children. The 11 States with the largest number of rural Negroes are:

State	*Rural Negro population in 1930* [1]
Mississippi	875, 731
Georgia	754, 488
Alabama	676, 384
North Carolina	672, 410
South Carolina	655, 327
Texas	525, 135
Louisiana	518, 863
Virginia	436, 764
Arkansas	389, 301
Tennessee	237, 478
Florida	221, 536

The percentage of the rural population in these States that was made up of Negroes varied from 52 in Mississippi to 13 in Tennessee.

In December 1936 the Children's Bureau added to the administrative staff of the Child Welfare Division a consultant whose services have been made available to the States to assist them in increasing the effectiveness of their services for Negro children.

The special consultant advises on request as to the development of child-welfare programs in relation to Negro children, gives special demonstrations of services in county or State programs, evaluates and assists in strengthening the public services that already exist and in initiating activities which will bring together the forces of public-welfare planning and the social resources within Negro communities.

DEVELOPMENTAL FACTORS RELATED TO SERVICES FOR NEGRO CHILDREN

In the section of the United States where the rural Negro population is concentrated, there is a decided biracial culture in which the races have majority and minority status. The extent to which the minority group is reached by public services depends on many complex factors.

In the development of child-welfare services for Negroes one of these factors was related to the progress made by the States in organizing administrative machinery. States such as Alabama and North Carolina that had well-established social services for children could begin immediately to extend more adequate services to Negro children. Another factor was the traditional practice of the State government in regard to considering Negroes as part of the total population for which all public services exist. Even in the States with long-established public services for all children, these services may not reach the Negro children effectively because of lethargy or because the need is not realized.

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[1] Fifteenth Census of the United States, 1930. Population, vol. 3, table 2 (tables for individual States).

STATE AND LOCAL PATTERNS OF DEVELOPMENT

Wherever States have approached their problems of developing social services adequately to meet the needs of Negro children as well as white children, they have followed one of two approaches or have used both simultaneously. One approach has been to develop the case-work program for children within State and local departments of public welfare through staff members serving children of both races. The second approach has been through the use of a special demonstration unit for Negro children administered by local departments of public welfare and staffed by Negro workers. Both methods seem necessary to an effective child-welfare movement, but each has values not inherent in the other.

In the development of case work for children by workers serving both races, the workers either are attached to local departments of public welfare or, in States where county development is not advanced, are assigned from the State agency staff to counties or districts. These local or regional workers are interested primarily in the prevention, through social case work and organization of community resources, of neglect, dependency, and delinquency in family and community life.

The second method—special demonstration by Negro workers—was first adopted by Alabama. In April 1936 the Alabama Department of Public Welfare assigned a Negro worker to the Macon County Department of Public Welfare to develop county services for Negro children. Since that time 20 other special demonstration units paid for from Federal funds have been initiated in various States. Some of the projects since have been discontinued, and others have been accepted as the financial responsibility of the State agencies creating them.

In the 1941 plans for child-welfare services provision has been made for 14 demonstration units to be financed wholly or partly from Federal funds. The States in which these special services are being continued or initiated are Alabama, Delaware, Kentucky, Michigan, New Jersey, North Carolina, Oklahoma, South Carolina, and Virginia.

GENERAL SERVICE FOR NEGRO CHILDREN

General service for Negro children is carried on by white child-welfare workers with responsibility for service to children of both races. The most important function of these workers serving Negro children as well as white is to guide the child's own family in meeting his needs.

Since the welfare of children has been overlooked in many rural communities, problems of the individual child are likely to be far advanced when they are first brought to the attention of the county department of public welfare. The case worker's task, therefore, becomes one of preventing maladjustment from progressing further. In addition to case work with children the county workers are concerned with creating community awareness of child-welfare problems and with stimulating the development of resources to cope with them. Many of these workers need special preparation for effective service to Negro families and communities. Workers equipped only with traditional ideas and attitudes in reference to Negroes are not adequately prepared to promote the welfare of Negro children.

For social work with Negro children child-welfare workers need a special facility which results from acquaintance with the fields of anthropology and sociology in addition to training in technical social work. This facility is necessary if social work among Negroes, particularly among "folk Negroes"[2] is to be practiced with understanding. This special approach throws light on the problems of an individual's growth in cultural isolation and social segregation and on the racial mechanisms that are developed to offset the results of such an enforced way of life.

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[2] The term "folk Negroes" is used here to refer to segments of Negro American population that are isolated from the general American culture over a long period and have substituted a folkway of life. This folk culture is scattered all over the United States and obtains in the midst of American ways of life, followed by both Negro and white populations.

The rural case worker meets the Negro child in his own cultural setting. She must understand some of the factors underlying these complex and constantly changing settings if she is to help him toward a way of life that provides a more stable and socially acceptable family structure.

An example of the need for such interpretation is found in the problem of children born out of wedlock among "folk Negroes." An understanding of some of the contributing factors will help the rural case worker to realize that irregular sex relations may be a symptom of psychological, social, or economic pressure rather than of immorality. For many of the "folk Negroes" in certain isolated sections, where opportunities for other satisfactions are limited, sex prowess in the male and childbearing in the female are proof of social adequacy. Among the young people they are proof of the attainment of adulthood.

Another significant factor is that among "folk Negroes" important family decisions are made by the women, especially by the maternal grandmother. It frequently happens that several children born out of wedlock are taken into the maternal grandmother's family. Usually the case record reveals that the maternal grandmother decides this shall be done, although the reasons for her decision are individual and conform to no set pattern. Any social case worker who becomes effective among Negroes must reckon with this authority. This vestige of a matriarchal order appears in family life even in less isolated Negro families and, therefore, is an important factor to take into account in developing substitute family care for Negro children.

Case workers dealing with children of both races are gradually learning how to work effectively with Negro children, their families, and their communities. This is significant for Negro children because, like other children, they can grow best in communities where there is active planning for and promotion of their development. It is significant in the field of social work because social workers who develop the facility to work with other races and in strange or different cultures increase the value of their services. The horizons of social work under the Social Security Act are extending beyond the 48 States into Puerto Rico and Hawaii. Both have large population elements with cultural backgrounds unfamiliar to the majority of social workers in the United States. The effectiveness of social services among the people of these areas requires something of the special facility necessary in the Southern States.

THE SPECIAL DEMONSTRATION UNIT

Service for Negro children in a special demonstration unit as developed in a county or State program has usually been focused on a particular problem related to the Negro community, but apparent to the entire community, such as juvenile delinquency. The social workers selected for these specific activities are Negroes. It is assumed that because of their racial identity these workers are more immediately effective with their own people than are workers of other races. They are selected by the same personnel standards as are all other workers with State and local departments of public welfare. The special units of service are planned by State agencies in relation to the entire program of child-welfare services.

The activities of a special unit are essentially the same as other services administered by State child-welfare agencies, and the areas selected are rural localities with large Negro populations in which the need for case work with children is pronounced. In addition to relieving the stress and strain in the lives of Negro children the special unit, if properly initiated and directed, may become a field clinic from which observations benefiting the entire program can be made.

For example, in one demonstration unit the worker was faced with an overwhelming amount of delinquent behavior among Negro children. In reviewing the cases of children under care she began looking for signs that indicated how the Negro children and their families arrived at a code of good behavior. After 2 years of observation she was inclined to believe that the standards of behavior for the

Negro children in this community are developed around the type of behavior that will keep them out of trouble in their biracial way of life. These standards are related to external factors, not to personal growth and development. The worker therefore concerned herself with developing case relationships that would motivate a boy or girl to achieve higher standards of behavior. But she had also to concern herself with the community attitude that behavior in violation of biracial codes, not written in the juvenile-court law, may be regarded as delinquent and may be dealt with by any member of the majority group rather than by the police, the sheriff, or the juvenile-court officers. The mere presence of a Negro child alone on the street at night, for example, was a violation of the biracial code. It is not easy to master the technique of effective service to Negro children in all the complex situations encountered nor to interpret to the community the reasons for the children's behavior, but each failure as well as each success is illustrative, informative, and useful. Herein lies the significance of the demonstration unit of service for Negro children.

Special demonstration units paid for from Federal funds for child-welfare services are initiated in the hope that when they prove their value the local government will assume responsibility for their support. In some cases the units have already been discontinued as a demonstration supported by Federal funds and have been incorporated in the system of local public services. This is not the only test of a special unit's success, but it is an indication of its value to the community.

Special Consultation to States

The type of assistance given by the Children's Bureau has been determined by the problems which the State agencies wanted to approach immediately. In several States progressive steps in expanding their activities for Negro children have resulted. The extent of service that the Children's Bureau can render in this field has been determined somewhat by the readiness of the States to explore fields of activity that are unfamiliar to them.

The first assignment undertaken by the special consultant involved defining the problems among Negroes in a rural county and evaluating the effectiveness of available social resources. The outstanding problems determined the type of assistance which the State program for child-welfare service could render. One problem arose not so much from the lack of community resources, such as public-health and welfare facilities, as from the fact that Negro parents and teachers did not understand how to make use of these facilities. Another problem was that few of the available social agencies recognized a responsibility for expanding their programs to meet the needs of Negro children. The leadership that the local department of public welfare wished to take in this direction would not have been possible without Federal funds to provide for additional personnel.

As one of the assets of this community was the forthright social attitude of several public officials, including the superintendent of public welfare, it was possible within a brief period of time to begin a demonstration unit of service for Negro children in this county. The special consultant from the Children's Bureau helped to organize the work to be undertaken by the children's case worker and advised the local department of welfare concerning approaches to be made and pitfalls to be avoided. For example, the service aspects of the local welfare program had been very little understood. The only contact that teachers and parents had with the department of public welfare was in connection with requests for relief and financial assistance. Although this was not a racial, but a community, concept of the department's function, the necessity of interpreting the opportunities for social service to teachers and to Negro community groups was compelling.

The local welfare department was encouraged to begin work for Negro children by strengthening family life and keeping children in their own or relatives' homes. There were children who needed care away from their own homes and even away from their communities, but there was considerable feeling in the locality against taking children away from their parents under any circumstances. By removing children from their homes the new child-welfare service could have been made unpopular to such an extent that cooperation of the Negro community would have been delayed.

Another typical activity of the Children's Bureau consultant has been that of evaluating existing services for Negro children. In many States the most widely used public resources for Negro children are the State correctional or training schools for boys and girls. Several evaluations have been made of institutional services to Negro children. This work is done under the direction of the Child Guidance Division of the Children's Bureau. These evaluations have invariably shown the need for more local community resources for Negro children as alternatives to commitment to an institution; for follow-up of children discharged from care; and for adequate training facilities within the institutions.

Several States with State-wide direct-care programs have made efforts to localize their direct-care activities by assisting counties to assume responsibility for services to children in the county. When this responsibility is related to Negro children, it becomes more complex, and, in the case of two States, assistance has been given by the Children's Bureau in planning the best possible procedures.

Interpreting racial problems to staff members of State and county departments of public welfare has been another feature of the special consultation service. In supervising children's workers in general and special services to Negro children, the case supervisors and consultants of State child-welfare services encounter racial situations which they would like to understand better. The Children's Bureau has not developed material on this subject but it has been able to put workers in touch with helpful sources of information, and in many cases studies and interpretations of Negro life in the United States are being added to the libraries of State departments of public welfare.

Because the communities in which Negro children grow up need leadership of stalwart quality, it has been necessary to indicate to State agencies the channels through which leadership may be developed. In the summer of 1940 a Child Welfare Institute for Rural Teachers was held at West Virginia State College. The purpose of the institute was to interpret for the Bureau of Child Welfare in the West Virginia Department of Public Assistance the resources available to teachers in their efforts to promote the growth, care, and protection of Negro children. Occasions of this sort for interpreting local, State, and Federal activities in the field of rural social work are significant because they are opportunities to bring together Negro leadership and public forces of social planning.

In conclusion, the services rendered each State by the Children's Bureau special consultation service begin at the point where the State child-welfare agency feels the need to explore problems relating to Negro children. Thus far this approach has assisted the State child-welfare agencies in meeting their responsibilities to Negro children more adequately and with sincerity and clarity of purpose.

BOOK NOTES

MEETING SPECIAL NEEDS OF THE INDIVIDUAL CHILD. Nineteenth Yearbook, *The National Elementary Principal* (Bulletin of the Department of Elementary School Principals, National Education Association), Vol. 19, No. 6 (July 1940), pp. 229–736. Washington, 1940. $2.

This yearbook deals with the problems of discovering and meeting the special needs of each child. The point of view is that real equality of educational opportunity does not mean providing the same school program for all children; rather, that such equality means providing programs that are equally suited to their varied characteristics and needs. However, "in meeting the special needs of a particular child, the school must ever be concerned with the child as a whole. It cannot effectively adapt its program to one aspect of a pupil's status, such as mental ability, without carefully considering his other characteristics. Since each child is an integrated unit, his various needs must be studied and met in relation to one another."

Among the special needs considered are facilities for individual guidance; for children of superior ability; for slow learning, disinterested, and retarded children; for physically handicapped children; for children with cultural and economic handicaps; and for children with personality problems.

Several articles and a selected list of references are presented on each of the main subjects taken up.

INTRODUCTION TO YOUTH, by Erdman Harris. Macmillan Co., New York, 1940. 221 pp. $1.75.

In this nontechnical, easily read book certain guideposts are set up for parents, teachers, ministers, and leaders to assist them in appreciating and dealing with the problems of adolescence. The author, who is a teacher and a lecturer at the Union Theological Seminary, believes that an understanding of the psychology of adolescents is necessary. "But it is important that a worker know when he is up against a case that is beyond him and calls for the attention of a medically trained psychiatrist."

Included is discussion, with many illustrations, on such topics as the making of speeches; teaching and learning, both formal and informal; conducting personal interviews with young people; guiding youth in the search for a philosophy of life; and a process of moral and spiritual guidance. Throughout, concepts of theology, psychology, and education are presented for understanding by the layman.

Suggestions are given for further reading, including references on adolescent psychology, works of fiction which throw light on the struggles of the young, books about boys and girls in school and college which are a source of insight into the problems of youth, and plays dealing with adolescents.

EMOTION AND CONDUCT IN ADOLESCENCE, by Caroline B. Zachry in collaboration with Margaret Lighty. D. Appleton-Century Co., New York and London, 1940. 563 pp. $3.

The present volume is devoted entirely to the findings of the study of adolescents conducted by the Commission on Secondary School Curriculum of the Progressive Education Association. In this study, begun in 1934 and concluded in 1939, adolescents were observed in manifold relationships in several public and private high schools and colleges and in some out-of-school situations. From such observations "emerged the recognition on the part of the study staff that the process of growth from childhood to adulthood in contemporary American culture groups requires of young persons certain major adjustments in emotion and conduct which are basic to later, adult adaptations. These tasks confront adolescents generally, although no two individuals experience them in quite the same way. It was held to be a chief function of the school to help adolescents in these basic adjustments in order that in adulthood they might function in personally satisfying and socially constructive ways; it was felt that secondary education had not taken these developmental processes sufficiently into account."

The staff of the study of adolescents, of which Miss Zachry was chairman, included educators, psychologists, psychiatrists, physicians, anthropologists, sociologists, and psychiatric social workers.

In the three parts of the book, the tasks of life adjustment with which the adolescent must cope are discussed in the light of interacting personal and cultural demands and with the interest of educators particularly in mind. Part 1, describing the process by which the adolescent comes to terms with himself as he is changing, includes information on such subjects as the changing body and the concept of self, social-emotional problems related to organic growth, differing influences upon boy and girl, adaptation to standards of conduct, and education and changing attitudes to the self (including sex and character education).

Part 2 is concerned with the developing personal relationships of the adolescent and their significance for his adaptations, in the years to come, as an adult member of a social group. Included is discussion of the influences upon development in personal relationships, changing relationships with adults and with peers, and education and changing personal relationships.

Part 3 traces the adolescent's changing attitudes to such basic social institutions as vocation, citizenship, and marriage.

The text is illustrated throughout by case histories and quoted opinions drawn from the study of adolescents.

D. H. F.

THE ADOLESCENT PERSONALITY; A STUDY OF INDIVIDUAL BEHAVIOR, by Peter Blos. D. Appleton-Century Co., New York and London, 1941. 517 pp. $3.

The case-history approach used in the study of adolescents is illustrated in this volume. Its underlying purpose, according to the author, is to convey information and insight about adolescent development to people in general concerned with youth and to educators in particular.

In the foreword by Caroline B. Zachry it is observed that the consistent trends underlying the apparent inconsistencies of the adolescent "are most clearly revealed by observing him in many different situations and by comparing the clues that come from different sources. It is toward this more intensive and many-faceted study of single cases that the present volume is directed." From more than 600 case histories collected by the study of adolescents, 4 were selected for presentation in this volume. These 4 case histories of adolescent children of various socioeconomic and educational levels include data, with interpretation, on the children's early lives, family histories, school records, and physical examinations. These data comprise a considerable proportion of the book.

A section dealing with the theory of adolescent development discusses the values of the case-study approach, the sources of strain and conflict during adolescence, typical adolescent behavior in response to strain, and the influence of early experiences upon adolescent development, and presents a concept of adolescent adjustment. The concluding chapter deals with education in relation to adolescent development.

D. H. F

• CHILD LABOR •
• YOUTH EMPLOYMENT •
• VOCATIONAL OPPORTUNITIES •

Child Labor and the Federal Government

The Supreme Court Makes Child-Labor History

By Ella Arvilla Merritt, *Industrial Division, U. S. Children's Bureau*

The decision of the United States Supreme Court on February 3, 1941, unanimously sustaining as constitutional the Fair Labor Standards Act of 1938, was an event of momentous importance in the history of efforts to control child labor in the United States. The case (*United States* v. *F. W. Darby Lumber Co. and Fred W. Darby*) came to the Supreme Court on appeal by the Government from the United States District Court for the Southern District of Georgia, which had held the act unconstitutional. The act had been challenged as an unconstitutional device to invade the province of the States and to control production. The case arose upon prosecution by the Government of the Darby Lumber Co. for violation of the wage and hour standards of the law. The Supreme Court held that all the restrictions of the act, including those relating to child labor, are well within the field of congressional control under the commerce clause, and specifically overruled the case of *Hammer* v. *Dagenhart* (247 U. S. 251), which in 1918 had declared unconstitutional the first Federal child-labor law as beyond the power of Congress to regulate interstate commerce.

The Fair Labor Standards Act had been in effect more than 2 years, and its practicability had been widely tested and approved by experience, before the Court of last resort put on it the seal of approval. Through denial of the channels of interstate and foreign commerce to the shipment of products of establishments violating the minimum standards which it sets up relating to wages, hours, and child labor, the act effectually requires compliance with those standards in such establishments.

The first attempt to establish a minimum child-labor standard effective without regard to State lines was the Federal Child Labor Law of 1916, the result of more than 10 years of effort by many State and local child-welfare organizations, by members of Congress, and by many other groups. Based, like the Fair Labor Standards Act, on the power of Congress to regulate interstate and foreign commerce, it went into effect nearly 25 years ago.[1] It had been in operation only 9 months and 3 days, when, on June 3, 1918, it was declared unconstitutional by the Supreme Court of the United States[2] on the ground that in attempting to regulate child labor in this way Congress had exceeded its constitutional power.

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[1] The first Federal bill was introduced by Senator Beveridge in 1906, but it was not until 1916 that Congress enacted a Federal child-labor law, to go into effect September 1, 1917. The bill which Congress finally passed on September 1, 1916, was the so-called Keating-Owen Bill, which prohibited the shipment in interstate or foreign commerce of goods produced in mines and quarries and in factories or manufacturing establishments, mills, canneries, and workshops, in which children were employed in violation of certain age and hour standards. These standards were a 16-year minimum age in mines and quarries, and in factories and the other establishments covered, a minimum age of 14, an 8-hour day, 48-hour week, and 6-day week, and a prohibition of night work for children under 16 (39 Stat. 675, ch. 432; Public, No. 249, 64th Cong.). It was administered by the Children's Bureau of the U. S. Department of Labor.

[2] *Hammer* v. *Dagenhart,* 247 U. S. 251.

The next law establishing a Federal minimum standard in this field was enacted on February 24, 1919, when Congress passed as part of the Revenue Act a provision for the levying of a tax of 10 percent on the annual net profits of any mill, cannery, workshop, factory, or manufacturing establishment, or of any mine or quarry, employing children in violation of the age and hour standards established by the former Federal child-labor law.[3]

This act became effective on April 25, 1919, and was administered by the Office of Internal Revenue, United States Treasury Department, until May 15, 1922, when it also was declared unconstitutional by the United States Supreme Court,[4] in an 8-to-1 decision, on the ground that Congress, under the guise of a tax which on the face of the act is a penalty, may not regulate a matter within the reserved rights of the States.

Another step toward a Federal minimum was made under the National Industrial Recovery Act, passed by Congress on June 16, 1933,[5] which provided for the establishment of codes of fair competition by agreement between industries, the National Recovery Administration, and the President. These codes, in addition to regulating wages and hours of labor for all workers, set up specific minimum-age standards for child workers. Practically all the 576 codes established under the act contained a basic 16-year minimum age for general employment and about three-fourths of them set a minimum age of 18 years for occupations especially hazardous or detrimental to health. The act was declared unconstitutional on May 27, 1935, on the ground that it attempted to regulate intrastate transactions which lay outside the authority of Congress and that it was an unconstitutional delegation of legislative power.[6]

In the meantime, immediately after the first Federal law had been declared unconstitutional and as a direct consequence of that decision, a widespread popular demand for the continuance of Federal child-labor legislation resulted in a proposal for an amendment to the Federal Constitution which would give Congress unquestioned power to legislate on the subject. In 1924 such an amendment was passed by both Houses of Congress and submitted to the States for ratification.[7] When the measure first came before the State legislatures progress in ratification was slow. Only 4 States ratified during the first 2 years, and only 6 States ratified up to 1933. With the depression, however, the economic as well as the social undesirability of allowing children to leave school for employment while millions of adults were idle became more and more obvious. Interest in the amendment was greatly stimulated, and 22 States have ratified from 1933 to the present time, making a total of 28 States [8] that have cast their vote in favor of adding this provision to the law of the land. Ratification by 8 more States is necessary to make it part of the Constitution.[9]

The finally successful effort to regulate child labor on a national basis was embodied in 1938 in the Fair Labor Standards Act,[10] which included provisions that prohibit the shipment in interstate or foreign commerce of goods produced in establishments in the United States in or about which oppressive child labor has been employed within 30 days prior to the removal of the goods. "Oppressive child labor" is defined as the employment of minors under 16 years of age in any occupation covered by the act and the employment of minors between 16 and 18 years of age in occupations which shall be found and by order declared to be hazardous by the Chief of the Children's Bureau. Children between 14 and 16 years of age may be employed in nonmanufacturing and nonmining occupations under regulations issued by the Chief of the Children's Bureau where such employment has been determined not to interfere with their schooling or their health and well-being. Children employed in agriculture when not legally required to attend school, children employed as actors in motion pictures or theatrical productions, and children working for their parents in occupations other than manufacturing or mining are exempted from the child-labor provisions of the act.

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[3] 40 Stat. 1138, ch. 18; Revenue Act of 1918, title XII.

[4] *Bailey* v. *Drexel Furniture Co.*, 259 U. S. 20.

[5] 48 Stat. 195, ch. 90; Public, No. 67, 73d Cong.

[6] *Schechter Poultry Corp.* v. *United States*, 295 U. S. 495.

[7] This proposed amendment does not itself set up child-labor standards. It reads:

Sec. 1. The Congress shall have power to limit, regulate, and prohibit the labor of persons under 18 years of age.

Sec. 2. The power of the several States is unimpaired by this article except that the operation of State laws shall be suspended to the extent necessary to give effect to legislation enacted by the Congress.

[8] The 28 States that have ratified the amendment are Arkansas, Arizona, California, Colorado, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Utah, Washington, West Virginia, Wisconsin, and Wyoming.

[9] The Supreme Court of the United States has decided that the amendment is still before the States for ratification (*Coleman* v. *Miller*, 59 Sup. Ct. 972).

[10] The Fair Labor Standards Act of 1938, 52 Stat. 1060, ch. 676; Public, No. 718, 75th Cong., 3d sess.

Justice Stone, who wrote the recent opinion holding the act constitutional, pointed out that the reasoning on which the opinion is based is not new but follows rather the well-established tradition of the Court, from which it had departed in *Hammer* v. *Dagenhart* in 1918. Referring to the fact that Congress intended the Federal act to bar interstate traffic in goods produced under substandard labor conditions, the Court said:

> The conclusion is inescapable that *Hammer* v. *Dagenhart* was a departure from the principles which have prevailed in the interpretation of the commerce clause both before and since the decision and that such vitality, as a precedent, as it then had has long since been exhausted. It should be and now is overruled

It was noted that the *Hammer* v. *Dagenhart* decision was "by a bare majority of the Court over the powerful and now classic dissent of Mr. Justice Holmes setting forth the fundamental issues involved." In that dissenting opinion, now followed as the law of the land, Justice Holmes expressed his feeling that there was no valid distinction between the power of the Federal Government to prevent the shipment in interstate commerce of lottery tickets or impure foods and drugs (a power already upheld by the Court), and power to forbid the channels of interstate commerce to the products of child labor. He said:

> The act does not meddle with anything belonging to the States. They may regulate their internal affairs and their domestic commerce as they like. But when they seek to send their products across the State line they are no longer within their rights. If there were no Constitution and no Congress their power to cross the line would depend upon their neighbors. Under the Constitution such commerce belongs not to the States but to Congress to regulate. * * * Instead of being encountered by a prohibitive tariff at her boundaries the State encounters the public policy of the United States which it is for Congress to express. The public policy of the United States is shaped with a view to the benefit of the Nation as a whole.

In its current opinion the Court says:

> The motive and purpose of the present regulation [the Fair Labor Standards Act] is plainly to make effective the Congressional conception of public policy that interstate commerce should not be made the instrument of competition in the distribution of goods produced under substandard labor conditions, which competition is injurious to the commerce and to the States from and to which the commerce flows.

Notwithstanding this decision, complete elimination of harmful child labor cannot be brought about without giving Congress power to regulate directly child labor in intrastate as well as interstate industries. This can be done through an amendment to the Constitution giving Congress power to set a minimum standard for all child labor. Application of the child-labor provisions of the Fair Labor Standards Act is limited to children working for employers producing goods for interstate commerce. Recent studies and reports indicate that a very large proportion of gainfully employed children under 16 years of age in the United States, outside the fields of agriculture, domestic service, and street trades, are in local industries which for the most part are not producing goods for interstate commerce. Thus they are not touched by the child-labor provisions of the Fair Labor Standards Act and their employment is regulated only by State law. Though many advances in State legislation have been made in recent years, State efforts to control child labor are uneven and inadequate. Completion of ratification of the pending child-labor amendment would make possible the achievement of national minimum standards for all children of the Nation.

BOOK NOTES

CHILDREN IN THE THEATER, by Anne Hood Harken and Gertrude Folks Zimand. Publication 382, National Child Labor Committee, New York, 1941. 94 pp.. $1.

Need for standards as to desirable State legislation regarding the employment of children on the legitimate stage and lack of information regarding conditions of employment for children in such work led the National Child Labor Committee to undertake a study of the employment of children as actors in legitimate-stage productions.

This study is based on:

> An intensive survey of 65 child actors under 18 years of age living in the metropolitan area of New York City; the survey covers their entire professional life both in New York and on the road.
>
> Examination of 1,138 permits issued by the mayor's office for children's appearances on the legitimate stage in New York City between September 1925 and June 1940. This figure represents the appearance of 695 children under 16 years of age in 398 Broadway plays.
>
> Interviews with 16 adults who had been child actors, and consultation with producers, stage managers, and playwrights.

The report of the study offers a real contribution in presenting concrete information on a group of child actors regarding the conditions of their employment during rehearsals and during the run of a play and regarding their health, schooling, and recreation, and also in reporting information and opinions bearing on educational and vocational aspects of the work of children on the legitimate stage.

The recommendations of the report outline measures that are needed to protect the child actor from undue strain. These deal with limitation of rehearsal hours, minimum age, work permits, and prohibition of other work (such as broadcasting in radio programs, acting in motion pictures, and posing as a model for commercial photographers) when a child is rehearsing for or appearing in a play.

Although this study was confined to children appearing in the legitimate theater, considerable information was obtained in regard to the employment of these same children in other fields. This has been presented by the National Child Labor Committee in a supplementary report (mimeographed) on the work the theater children who were studied have done in radio broadcasting, commercial photography, and motion pictures.

REPORT ON PROGRESS OF THE WPA PROGRAM. Work Projects Administration, Washington, 1940. 147 pp.

The report, which is illustrated with charts and photographs, covers activities during the fiscal year 1940, provisions for the 1941 program, project accomplishments, operative policies and procedures, and the WPA and national defense. The chapter on national defense points out that by June 1940 preference was being given to WPA projects in strategic areas and new defense projects were being approved rapidly and placed in operation.

Civil-Service Commission Bars Minors From Hazardous Occupations

The United States Civil Service Commission has advised the Children's Bureau that it desires to cooperate fully in effectuating the principles of the child-labor sections of the Fair Labor Standards Act in civil service. It has issued instructions to insure that persons under 18 years of age will not be appointed for service in occupations that have been designated by the Children's Bureau as particularly hazardous for the employment of minors under 18, and, therefore, are subject to the 18-year minimum-age standard under the Fair Labor Standards Act.

CONFERENCE CALENDAR

Apr. 29	Conference of State and Territorial Health Officers with the United States Public Health Service, Washington, D. C.
Apr. 30	Conference of State and Territorial Health Officers with the Children's Bureau, Washington, D. C.
Apr. 30–May 3	National Education Association. Department of Health, Physical Education, and Recreation, Atlantic City, N. J.
May 5–8	National Tuberculosis Association. Annual meeting, San Antonio, Tex.
May 5–9	American Association of University Women. National biennial convention, Cincinnati, Ohio.
May 11–14	American Society of Planning Officials. National conference on planning, Philadelphia, Pa.
May 19–22	National Congress of Parents and Teachers. National convention, Boston, Mass.
May 19–24	General Federation of Women's Clubs. Golden jubilee triennial convention, Atlantic City, N. J.
May 22–24	American Pediatric Society. Hot Springs, Va.
May 25–29	American Public Health Association. Western branch, San Diego, Calif.
May 26–30	National League of Nursing Education. Annual convention, Detroit, Mich.
May 28–29	Association of Juvenile Court Judges of America. Annual meeting, Boston, Mass.
May 29–31	National Probation Association. Annual conference, Boston.
May 30–31	American Heart Association. Scientific meeting, Cleveland, Ohio.
May 30–31	American Association of Social Workers. Delegate conference, Atlantic City, N. J.
May 31–June 1	Community Chests and Councils, Inc., Atlantic City, N. J.
June 1–7	National Conference of Social Work. Sixty-eighth annual session, Atlantic City, N. J.
June 2–6	American Medical Association, Cleveland, Ohio. Chairman Hotel Committee: Dr. E. F. Kieger, 1604 Terminal Tower, Cleveland.
June 5–9	National Conference of Jewish Social Welfare, Atlantic City, N. J.
June 19–25	American Library Association. Sixty-third annual conference, Boston, Mass.
June 22–26	American Home Economics Association. Thirty-fourth annual meeting, Chicago, Ill.
June 23–25	Masonic Homes Executives Association of the U. S. A. Eleventh annual conference, Dousman, Wis.
June 29–July 3	National Education Association, Boston, Mass. Information: N. E. A., 1201 Sixteenth Street NW., Washington, D. C.
July 6–11	National Federation of Business and Professional Women's Clubs. Sixth biennial convention, Los Angeles, Calif.
July 8–12	Association for Childhood Education. Forty-eighth annual convention, Oakland, Calif.
July 13–18	American Physiotherapy Association. Twentieth annual convention, Asilomar, Calif.
Aug. 10–13	International College of Surgeons, Mexico City, Mexico.
Sept. 15–21	Second Inter-American Congress of Municipalities, Santiago, Chile.

U S GOVERNMENT PRINTING OFFICE: 1941

the CHILD
Monthly Bulletin

PUBLIC-HEALTH NURSE IN A RURAL HOME

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

APRIL 1941

U. S. SUPERINTENDENT OF DOCUMENTS
MAY 15 1941

THE CHILD

MONTHLY BULLETIN

Volume 5, Number 10 April 1941

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The Children's Bureau does not necessarily endorse or assume responsibility for the statements or opinions of contributors not connected with the Bureau.

CHILD HEALTH DAY—1941

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A PROCLAMATION

WHEREAS the Congress by joint resolution of May 18, 1928 (45 Stat. 617), has authorized and requested the President of the United States to issue annually a proclamation setting apart May 1 as Child Health Day:

NOW, THEREFORE, I, FRANKLIN D. ROOSEVELT, President of the United States of America, in recognition of the vital importance of the health and strength of the children of the Nation, do hereby designate the first day of May of this year as Child Health Day.

And I call upon the people of each community of the United States on that day to review the extent to which they are providing for children nutritious food, healthful recreation, effective health supervision, and adequate medical care, and to plan how such protection can be extended to all our children.

I also call upon children to take full advantage of their opportunity to grow in health and strength and to share in protecting the health of other boys and girls.

IN WITNESS WHEREOF I have hereunto set my hand and caused the seal of the United States of America to be affixed.

DONE at the City of Washington this seventh day of April in the year of our Lord nineteen hundred and forty-one and of the Independence [SEAL] of the United States of America the one hundred and sixty-fifth.

FRANKLIN D. ROOSEVELT

By the President:
CORDELL HULL,
Secretary of State.

• BIRTH • GROWTH • CHILD HEALTH •

The Economical Purchase of Vitamin-D Preparations

By J. Ernestine Becker

Specialist in Nutrition, Maternal and Child Health Division, U. S. Children's Bureau; Associate in Biochemistry, School of Hygiene and Public Health, The Johns Hopkins University, Baltimore, Md.

The disruption and disorganization of shipping by the present European conflict and the fact that fish from foreign waters have in the past been the chief sources of cod-liver oil and certain other fish-liver oils make consideration of sources and cost of antirachitic agents of immediate concern. In 1939, 35 percent of the 6,670,000 gallons of cod-liver oil imported by the United States came from Norway and 26 percent from Iceland. In 1940 only one-third (2,114,000 gallons) of this amount was imported. The 1,400,000 gallons from Iceland constituted 66 percent of this amount and only 11 percent (224,000 gallons) came from Norway. With the supply of Norwegian oil cut off, a scarcity has developed, prices of cod-liver oil have risen, and the use of other sources of vitamin D has increased.

The discovery that there are 10 or more forms of vitamin D is of purely academic interest, as the medical practitioner need concern himself only with those forms which are of practical interest. These are vitamin D of fish-liver oils, that produced by exposure of the skin to ultraviolet rays from natural or artificial sources, and that produced by activation of a precursor (ergosterol) from yeast. These forms appear to be of equal value to the human infant and thus may be prescribed interchangeably.

Since many factors enter into the efficiency with which exposure to direct sunlight can be utilized to produce vitamin D it is desirable in most parts of the United States to give all babies and small children vitamin D from an additional source.

The great number of preparations available necessitates the adoption of some criterion or criteria for selection on an individual or community basis. It is the purpose of this article to enumerate the kinds of products that are available and to suggest the factors that should be considered in making a selection, as maternal and child-health workers frequently are called upon to do, for use in families or for distribution by health departments and welfare or voluntary agencies. Only antirachitic preparations intended for oral use will be considered here. These include fish-liver oils, enriched and fortified fish-liver oils, concentrates of fish-liver oils, activated ergosterol and 7-dehydrocholesterol, and vitamin-D milks.

Vitamin-D Dosage

The prophylactic dose of vitamin D endorsed by authorities varies. For a baby, 800 units per day throughout the first and second years of life has been recommended by the Children's Bureau.[1] For older children 400 units a day is generally accepted as sufficient. Physicians generally subscribe to the practice of supplementing the diet of women during pregnancy and lactation with vitamin D. Park[2] recommends 800 units a day for the pregnant woman. The amount of cod-liver oil or other preparation needed daily to supply 800 units depends on its potency in vitamin D (table 1).

---

[1] Substitutes for the Sun. Children's Bureau Folder 25. Washington, 1940.

TABLE 1.—*Approximate amounts of cod-liver oil and of other preparations needed to supply 800 U. S. P. units of vitamin D*[1]

If the cod-liver oil or other preparation contains in each gram the amount of vitamin D shown below—	The approximate amount that should be given daily to supply 800 units will be—
85 units	2½ teaspoonfuls
175 units	1¼ teaspoonfuls
250 units	¾ teaspoonful
400 units	½ teaspoonful
1,000 units	40 small drops
5,000 units	8 small drops
10,000 units	4 small drops

[1] Substitutes for the Sun. Children's Bureau Folder 25.

In selecting a source of vitamin D cost per unit is an important criterion. Variations in cost will be considered later.

Since vitamin D from natural sources occurs usually in combination with vitamin A and since amplification of the diet with vitamin A is usually an advantage, the amount of this factor that can be obtained in combination with a desirable level of vitamin D is another important criterion. Except in the case of vitamin-D milk for infants and children, the purchase of other dietary essentials along with vitamins A and D is not economical nor is it advisable from the viewpoint of a nutritionist. Table 2 (p. 249), which gives costs of vitamin D from various sources, affords convincing proof of the relatively high cost of the "gun shot" type of vitamin therapy or prophylaxis.

The Food and Drug Administration of the United States Federal Security Agency conducts assays on commercial vitamin preparations representative of those available for sale. It is responsible for seeing that the standards of potency established by the United States Pharmacopœia are maintained. That Administration also checks the accuracy of statements relating to the vitamin content of preparations other than those included in the United States Pharmacopœia. Hence a statement on the label of a preparation of its vitamin potency in U. S. P. units affords some assurance of its reliability.

Cod-Liver Oil as an Antirachitic Agent

The best known of the fish-liver oils is cod-liver oil. It is the time-honored remedy for the prevention and cure of rickets. The United States Pharmacopœia, XI Revision, 1939 Supplement, requires that cod-liver oil contain not less than 850 units of vitamin A and 85 units of vitamin D per gram. The level of vitamin A of standard cod-liver oil has been raised by the United States Pharmacopœia from 600 to 850 units per gram within the last 2 years. Previously the Council of the American Medical Association had determined upon this standard and had granted its seal of approval and listing in New and Nonofficial Remedies only to those products having this or a higher potency. Thus the standards of the two are now the same.

Most cod-liver oils sold in the United States have a potency of at least 100 units of vitamin D per gram and many are 2 to 4 times as potent as the official standard requires. Thus 1 teaspoonful of cod-liver oil (about 4 grams) supplies about 340 units if the product conforms to the U. S. P. minimum requirements and 400 or more if the potency is 100 or higher.

Park[3] sets forth the advantages and disadvantages of cod-liver oil as follows:

> Its advantages are: It is extremely effective in the treatment of rickets * * *; it is universally available; despite assertions to the contrary, it is safe; it contains vitamin A in abundance (about 1,000 units per gram); and its fat is a valuable addition to the diet of many infants. The disadvantages are its lack of concentration, which makes the dose requirement large, and its fishy taste.
>
> * * * Cod-liver oil is therefore not potent enough—not enough can be given—to prevent or cure

---

[2] Park, Edwards A.: The Use of Vitamin D Preparations in the Prevention and Treatment of Disease. The Vitamins; a symposium, ch. 27. American Medical Association, Chicago, 1939.

[3] Id.

rickets in some premature babies and in especially susceptible full-term infants and older children. It is not the best remedy to stop rickets quickly.

The fishy taste of cod-liver oil virtually precludes its use in the case of the older child and adult. Most infants, however, will take it well and may even develop a liking for it if its administration is begun early and it is given regularly. If it is not given until toward the end of the first year or if its use is allowed to lapse, difficulties in administration will arise. When an infant refuses cod-liver oil the trouble usually lies with the mother, who transfers her feelings and prejudices. The ease and success with which cod-liver oil may be given to children over 2 years of age when the force of example is brought into play, as in nursery schools, bear witness to the influence of adults. One of the obstacles to the use of cod-liver oil in the lay mind is the deep-rooted belief that it causes digestive disturbances, especially in hot weather, and that some infants are constitutionally unable to take it at all. Cod-liver oil rarely gives rise to digestive disturbances and can be administered in hot weather without any difficulty.

OTHER FISH-LIVER OILS

Oils from the salmon, sardine, shark, and burbot contain appreciable amounts of vitamin D. Halibut-liver oil, also known commercially as haliver oil, is about 60 times as rich in vitamin A and at least 4 times as potent in vitamin D as is cod-liver oil. The oil of the blue-fin tuna has the enormous concentration of 40,000 units of vitamin D per gram. From this fish and others of the percomorph group is derived the familiar percomorph oil. Where the caloric or fat intake must be restricted, where higher dosage of vitamin D is desired, or where cod-liver oil is contraindicated such preparations can be safely prescribed. The dosage of preparations of high potency is indicated in drops rather than teaspoonfuls.

ENRICHED AND FORTIFIED FISH-LIVER OILS

Fish-liver oils may be enriched with viosterol or some natural source of vitamin D to varying degrees of potency. The labels on 24 preparations showed a range of 375 to 10,000 units of vitamin D per gram. The most usual combinations are halibut-liver oil and viosterol, percomorph and cod-liver oil, cod-liver oil and viosterol, and cod-liver and halibut-liver oils.

Where combinations of halibut-liver oil and viosterol are made, the vitamin-A content is usually 50,000 units per gram and the vitamin-D content, 10,000 units per gram. One mixture of percomorph and cod-liver oil had potencies of 60,000 units of vitamin A and 8,500 units of vitamin D per gram; another was only one-tenth as potent. Most available combinations of cod-liver oil and viosterol have a vitamin-D content of 400 units per gram but the vitamin-A content varies. In 5 brands noted there was a range of 1,500 to 2,250 units of vitamin A per gram.

Mixtures of cod-liver and halibut-liver oils are not widely used; two had potencies of 3,750 and 4,200 units of vitamin A per gram and potencies of 375 and 700 units of vitamin D per gram.

CONCENTRATES AND HOW THEY ARE ADMINISTERED

Available, too, are concentrates made from cod-liver oil and from activated ergosterol and carotene in oil. Cod-liver oil concentrate (the nonsaponifiable portion of the oil) is marketed in liquid, capsule, and tablet form. Four of these preparations in liquid form, to be administered in drops, varied in concentration from 3,400 to 8,500 units of vitamin D per gram.

In capsule and tablet form 15 products showed a range of 85 to 1,450 units per capsule or tablet. In these forms the fishy taste of the oil is concealed. For adults and older children this is an advantage. For the infant, having the daily allowance in a single, pre-measured dose is an advantage. The capsule can be pricked or the top snipped off with scissors and the oil delivered directly into the baby's mouth. This procedure eliminates the danger of contamination and the development of rancidity that occurs when the bottle of oil is not kept clean and when it is repeatedly left open in a warm room. Convenient capsules are now available provided with easily removable tips.

Furthermore, dispensing with the "spoon with the fishy taste" appeals to the busy mother and fastidious housewife.

Capsules containing viosterol and carotene in oil and viosterol and dicalcium phosphate are available. They are useful where fish-liver oils cannot be tolerated or where supplementation of the diet with minerals as well as with vitamin D is indicated. The potency of these preparations is given on the label, and the dose varies accordingly.

High-potency preparations administered in drops, capsules, or tablets have certain advantages over cod-liver oil. They are easier to administer because the dose is small, an important consideration for the premature infant, the child refractory to the ordinary therapy of rickets, and the child or adult with a physiological intolerance or aversion to fat.

There is an extensive list of concentrates whose formidable names do not reveal the source or sources of vitamins A and D. In using a product of this type one is dependent entirely upon the label for enlightenment on its nature and vitamin potency.

Activated Ergosterol (Viosterol) and 7-Dehydrocholesterol

Under ordinary circumstances reasons of economy indicate the use of preparations containing both vitamin A and vitamin D, but occasionally the physician will wish to give vitamin D alone or in addition to what is derived from a common source of the two. For these purposes viosterol is available. This is activated ergosterol dissolved in corn oil or some other bland oil. Viosterol is now manufactured in two ways, one by means of ultraviolet irradiation, the other by bombardment with low-velocity electrons. The two processes yield products that are identical. As marketed, both have a required potency of at least 10,000 units of vitamin D per gram, about 230 units per drop.

Viosterol in oil is tasteless and easily administered. It is well adapted for the use of older children and adults. The disadvantage, compared with the fish-liver oils, is that it does not supply vitamin A.

There is also available a vitamin-D preparation of irradiated ergosterol dissolved in paropylene glycol. It is soluble in water and so can be mixed directly with the milk.

Since the discovery that 7-dehydrocholesterol, like ergosterol, can be activated by irradiation, this substance dissolved in an inert oil has been demonstrated by clinical tests to be an excellent antirachitic agent. This is now obtainable.

Vitamin-D Milks

For more than a decade milk—both fresh and evaporated—has been available, the vitamin-D content of which has been increased in one of three ways. By passing milk in a thin film before a source of ultraviolet light a vitamin-D milk is produced with a potency of 135 units per quart. Recent modifications in procedure yield irradiated milk having 400 units per quart without the production of objectionable flavor. Milk produced by cows fed irradiated yeast is also standardized at 400 units of vitamin D per quart. Fortified vitamin-D milk is produced through the direct addition of a vitamin-D emulsion made from a concentrate of cod-liver oil or other fish-liver oils, or from activated ergosterol. It is standardized at 400 units per quart.

Because milk is the chief constituent of the infant's diet and because of its merits as a food for persons of all ages, it is an ideal purveyor of vitamin D. One disadvantage is its low potency. For the infant and young child it is usually advisable to give additional vitamin D so that the daily intake is approximately 800 units.

How to Select a Source of Vitamin D

Advertisements with sales appeal and the persuasive talk of skilled salesmen are not safe guides to the selection of a source of vitamin D.

When a label states only that the product meets U. S. P. requirements the purchaser has no way of determining its exact potency. One knows only that the oil or mixture must contain at least 850 units of vitamin A and 85 units of vitamin D per gram. However, it would be safe to assume that the product is not substantially higher in potency. If such a preparation can be bought at a saving its purchase may be considered. It is to be hoped, however, that all pharmaceutical houses will recognize the wisdom of including in the subject matter of their labels the potency of their products in vitamins A and D. Only if this information is available can one determine accurately the actual amount to be prescribed and the form that affords this dosage at the lowest cost.

There is no one best source of vitamin D. There is no conclusive evidence of the superiority of any one form of vitamin D since all forms of this vitamin have been shown to produce the same effect when the amounts given contain equal numbers of U. S. P. units. The kind to be prescribed is a matter of price and choice.

Prices of the same product vary from time to time and from community to community. Comparative shopping is therefore necessary. After prices have been obtained from various pharmaceutical houses as well as from local jobbers and the cost per dose of vitamin D calculated, differences will be readily apparent.

Table 2 gives ample evidence of the striking differences in the cost of the same quantity of vitamin D from various sources. On a retail basis the most expensive source, V, halibut-liver-oil capsules in lots of 50, costs 25 times as much as VIII, a blend of natural fish-liver oils, in 50-cc. bottles. The contrast is all the more striking when one considers that all the preparations listed are dispensed by the same manufacturer. Cod-liver oil (I) is 2 to 4 times as expensive as VIII. Moreover, a 50-cc. bottle of VIII is a cheaper source of vitamin D than a 10-cc. bottle. Nevertheless, unless the larger quantity can be used promptly so as to avoid the development of rancidity and loss of potency, especially of vitamin A, purchase of the smaller bottle would be advisable. Thus, even if the cost is somewhat higher, if a bottle is to be used for one person only, a 10-cc. bottle estimated to last 30 days would be a wiser choice than a 50-cc. bottle lasting 150 days.

On a wholesale basis Ia, cod-liver oil purchased by the gallon, costs the same as VIIIa, blend of natural fish-liver oils purchased in dozen lots of 10-cc. bottles. If 50-cc. bottles are purchased in dozen lots, 800 units of vitamin D cost $0.001 less from VIIIa than from Ia.

It is logical to assume that similar price variations prevail among products of any one manufacturer. Furthermore, it is probable that even more striking contrasts in price occur between similar products offered by competing manufacturers. For example, a product similar to product IX has been found, which may be purchased in large quantities at a cost of $0.0013 for 800 units of vitamin D.

CONCLUSION

The war in Europe has so seriously affected the shipment of cod-liver and other fish-liver oils that a relative scarcity exists which may become intensified. Because of this the price of cod-liver oil has increased. Other sources of vitamin D of equal effectiveness and of greater concentration are available. Selection of the kind and brand to buy is the problem that confronts many workers in maternal and child-health divisions of State health departments. The following suggestions are made to serve as a basis for selecting a source of vitamin D:

1. Buy only products that have their potency in U. S. P. units of vitamin D recorded on the label, so that the amount containing the desired dosage and the cost per dose may be calculated.
2. Determine the daily intake on the basis of the vitamin-D units desired and disregard the dosage suggested on the label. It is often too high.
3. Buy preparations containing only vitamins A and D rather than mixtures of the "gun shot" type.
4. Buy the size of container that can be used to best advantage.

TABLE 2.—*Relative cost of 800 units of vitamin D from specified products*[1]

Product	Size of bottle	Current minimum list price	Cost of 800 units of D[2]	Amount to furnish approximately 800 units of D daily
Retail:				
I. Cod-liver oil (260 units per gram)	4 oz 12 oz 24 oz	$0.47 .89 1.49	$0.013 .008 .007	¾ teaspoonful.
II. Cod-liver oil and viosterol (400 units per gram).	3 oz 16 oz	.53 2.13	.012 .009	½ teaspoonful.
III. Cod-liver oil and halibut-liver oil (375 units per gram).	8 oz	.97	.009	½ teaspoonful.
IV. Halibut-liver oil (850 units per gram)	10 cc 50 cc	.43 1.49	.040 .028	40 drops.
V. Halibut-liver oil (170 units per capsule)	50 capsules 100 capsules 250 capsules	.79 1.29 2.59	.074 .061 .049	5 capsules.
VI. Halibut-liver oil and viosterol (10,000 units per gram).	5 cc 20 cc 50 cc	.74 2.23 4.49	.012 .009 .007	4 drops.
VII. Halibut-liver oil and viosterol (1,700 units per capsule).	25 capsules 100 capsules	.89 2.69	.017 .013	1 capsule every other day.
VIII. Blend of natural fish-liver oils (10,000 units per gram).	10 cc 50 cc	.57 1.97	.005 .003	4 drops.
IX. Blend of natural fish-liver oils (1,700 units per capsule).	25 capsules 100 capsules 250 capsules	.59 1.97 3.89	.011 .009 .007	1 capsule every other day.
X. Blend of natural fish-liver oils with malt compound (6,000 units per fluid ounce).	16 oz	1.69	.014	1 teaspoonful.
XI. A and D tablets (660 units per tablet)	80 tablets 250 tablets	.79 1.98	.012 .010	5 tablets per week.
XII. Viosterol (10,000 units per gram)	5 cc 50 cc	.53 3.19	.008 .005	4 drops.
XIII. A, B, D, G capsules (1,000 units per capsule).	25 capsules 250 capsules	.98 6.39	.031 .020	6 capsules per week.
XIV. A, B, C, D, G capsules (1,000 units per capsule).	25 capsules 250 capsules	1.39 9.69	.044 .031	6 capsules per week.
Wholesale:				
Ia. Cod-liver oil (260 units per gram)	1 gal	3.50	.003	¾ teaspoonful.
VIIIa. Blend of natural fish-liver oils (10,000 units per gram).	10 cc 50 cc	[3] 4.59 [3] 14.27	.003 .002	4 drops.

[1] All products listed are those of one manufacturer.

[2] The potency of most preparations is indicated in U. S. P. units on the label. The content of bottles is expressed in cubic centimeters or fluid ounces or number of capsules or tablets. For simplicity in calculation and because the preparations differ in specific gravity the weight of 1 cubic centimeter of oil has been reckoned as being 1 gram.

[3] Per dozen.

School by Telephone

The Electrical Two-Way Teaching Device for Crippled Children in Iowa

By W. A. WinterStein

Statistician, Department of Public Instruction, Des Moines, Iowa

For some years Iowa accepted responsbility for furnishing education to its physically handicapped children. Originally this was done through a program of transportation for those who could be brought to the classroom and through a program of home instruction by means of a visiting teacher for those whom it was impossible to transport. Funds, appropriated biennially by the legislative assembly, are used by the Department of Public Instruction to reimburse the school district for the child's transportation or to reimburse the school district for one-half of the extra expenditure involved in providing a visiting teacher. The reimbursement is limited in all cases to $10 per child per month.

The Department of Public Instruction has been constantly embarrassed by limited funds in the face of many applications. Much thought has been given to possibilities for improving the instruction program for children who are unable to participate in classroom activities. Consequently in September 1939 the Department instituted an experiment in adapting ordinary commercial intercommunication instruments to classroom instruction.

Placed in the child's room is a box-like instrument resembling a small radio set. On the teacher's desk at school is another matched to it. The child hears everything that goes on in the classroom, and he also recites when called upon.

The first set was installed in the Newton schools under the supervision of Superintendent B. C. Berg.

Mr. Berg had a high-school student, a junior, recently returned from the hospital, who expected to be confined to her bed or room for the entire school year. She was a normal student in everything save her physical disability. The first unit of the electrical two-way teaching device was installed for her use. Necessary adjustments have proceeded until the instruments now work satisfactorily.

Public interest called attention to the service rendered. The parents of the student were greatly pleased. The instructional value was apparent. The student made such progress academically, in morale, and physically that, exceeding expectations, she was able to return to school at the end of the semester. A telephone employee in Newton, noting the success of the work with the high-school junior, prepared a set for the use of his fifth-grade daughter who suffered from a form of paralysis. Two other young people in the Newton Schools and later a third one procured sets. All proved of measurable worth.

In the meantime, the experiment was extended to other school systems and met with the same success. Teachers and administrators, as well as pupils, parents, and friends, uniformly expressed satisfaction and approval.

In one of our rural districts a lad just entering his teens came in contact with a high-voltage line near his farm home and was terribly burned. After years of the best surgical and medical care, the boy remained an invalid, unable to control or use his body below the waist. He was anxious to acquire an education, being ready for work in the sixth grade. Local school authorities were much interested. Telephone wires were strung between the farm home and the one-room schoolhouse half a mile away. He is continuing his educational program and making very satisfactory and uniform progress.

In Iowa in the fall of 1940 infantile paralysis found many victims. At least three high-school students—a senior, a junior, and a sophomore—fell victims. By means of the intercommunication system, each of these is carrying a full load of school work creditably. Three of the pupils, in three communities, using this system are reported to be leading their respective classes in grades. In one city school system one of the classes elected the shut-in as class president.

Now, in its second year, the plan of educating home-bound physically handicapped children by means of the electrical two-way teaching device and the services of their own classroom teacher has been adopted for recommendation in all cases where, after careful study, the circumstances seem to warrant its use.

The Department does not recommend the use of the plan before a child has had sufficient classroom experience to interpret clearly the classroom instruction and discussion as it is heard over the teaching device. It would seem, too, to be necessary that the child should be sufficiently mature mentally to visualize classroom procedure. Where such experience and maturity concur and where the attending physician and the school superintendent in charge join in recommending an instructional program, the Department unhesitatingly recommends the use of the electrical two-way teaching device wherever classroom attendance is impracticable.

Something more than 100 sets are now in use in various Iowa school districts. Forms of disability from which the pupils suffer include cardiac and pulmonary troubles, broken backs, infantile and spastic paralysis, and all types of physical injuries and disasters. In most instances the service will necessarily be continuous until high-school graduation, but in three instances recovery of the pupil has permitted the release of the equipment for use elsewhere.

Distance between classroom and home varies, of course, with the circumstances. Some homes served are in the next block to the schoolhouse grounds. The longest distance for such service we have yet encountered is a trifle more than 5 miles.

The cost of equipment, adjustments, and installation has been approximately $40 per pupil served. As additional pupils are served by the equipment already purchased, the average will decrease. Maintenance and operating costs are comparatively low. The leased pair of wires between classroom and home cost the school district $1.25 per month for the first quarter mile and $0.75 per month for each additional quarter mile. The use of the equipment gives immeasurably better service than any other practical form of instruction for the home-bound and reduces the cost to a fraction of what was formerly paid for home instruction.

Standard equipment consists of a master station using power and a substation, both equipped with the necessary transformers for satisfactory use over a pair of continuous wires of required length. If more than one classroom is wired, the school wires should be brought to a conveniently located junction box where they can be distributed and redistributed, as the need may arise.

The classroom telephone terminal should be at the center front for best results. The home terminal may be located in the room to be used by the pupil wherever convenience suggests and near an electric outlet where power for operating the device is available. It is recommended that the classroom unit be used upon a shelf 18 by 8 inches, with insulation-board cover and back, placed at the center front of the classroom, about 5½ feet from the floor. If the shelf is mounted on strap iron and two screws placed in the wall at the appropriate height, the shelf may be transported from room to room with the device, as occasion requires.

It is recommended that the seller of the equipment be required to make installation, as some costly mistakes have been made in local attempts at installation.[1]

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[1] Acknowledgment should be made of the practical assistance rendered by the major telephone company operating within the State. This company has consistently waived the service fee usually charged for new installations and has thus encouraged a considerable number of school districts to begin serving home-bound pupils.

Thanks are also due to the State selling agents of two lines of commercial intercommunication equipment, who have experimented with their instruments under classroom and home conditions until they have succeeded in adapting them to satisfactory instructional service. The Department of Public Instruction has prepared a circular dealing with the problems of installation which will be forwarded to interested applicants.

Safeguarding Children in Camp

By Dorothy V. Whipple, M. D.

Division of Research in Child Development, U. S. Children's Bureau

As the first warm days of spring appear, many children and their parents begin to think about summer vacations and some of them turn their thoughts to camp as the ideal solution for a short vacation or for a long summer holiday. The popularity of camps for children has greatly increased within the last decade. The rapid growth of camp attendance has tempted many individuals and groups to organize and run camps for children. Some of these camps are splendid places for children to spend a happy, healthful vacation, but others are unsatisfactory, and children come home from them in a run-down and sickly condition. Sometimes children need a vacation to recover from the effects of the camp.

Parents should select very carefully the camp for their children, and to help them do so there are various standards by which the health standing of the camp can be judged.

It is perhaps wise, before attempting to select a camp, for parents to think out clearly what it is they want for their child in a summer spent at camp. Some things all parents want, others are needed only for children with special needs. All parents want their children to be in a place where they will be happy, where they will be safe, where they will be healthy. Most parents want, in addition, their children to benefit from the experience of being with their contemporaries, of being away from their parents, and of being in an environment where they may enjoy experiences impossible at home, such as swimming, sailing, horseback riding, hiking, or whatever it is that the camp selected has to offer.

Occasionally parents want special things from a camp. They may want to aid a shy child by giving him a place among other children his age, they may want a child to do extra academic work during the summer, or they may want to build up the health of a delicate child. Whatever the special requirements may be, the basic needs of every child in camp are to be safe and well and happy. It is with regard to these needs that it is possible to draw up certain standards by means of which parents can judge the adequacy of the camp they are considering for their choice.

The location of the camp, its facilities for healthful living, and the training and experience of its staff, especially its director, are the items which parents must evaluate in selecting a camp.

Location.—The camp chosen must be located in a place where the general health conditions are good. It must be on well-drained ground where neither flies nor mosquitoes constitute a major problem. It should not be in woods so dense that sunlight cannot penetrate to the camp buildings and grounds. Facilities should be available for the usual summer activities, so that the children experience the benefits of outdoor life.

Water.—An adequate supply of water is essential. Water for drinking should be known to be safe; it should be tested in the State laboratory or some other recognized place of examination. In addition to safe drinking water a camp should have plenty of water for washing purposes. A supply of hot water is essential to keep children clean, and cleanliness is essential to health. Some shower baths are essential in addition to at least one washstand for every eight children.[1]

Waste disposal.—A camp should have adequate sanitary facilities for the disposal of waste products, both human waste and kitchen waste. Flush toilets are in general better than privies, although if privies are properly constructed they may not cause any health hazard. Open-pit privies, however, cannot be accepted as adequate equipment. Some States require only 1 toilet for every 15 persons of the same sex. One for each 7 or 10 is a more desirable standard.[2] The kitchen waste must be disposed of in such a way that flies do not accumulate around it.

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[1] American Camping Association: Workshop on Camp Standards (First Draft of Report), Appendix B, National Park Service Memorandum to Field Officers. [New York, 1940.]

Heating facilities.—Many camps are located in regions where the temperature is too low for comfort at certain times during the summer, especially in damp and rainy weather. There should be some place on the camp grounds equipped with heating facilities where the children can congregate on rainy days.

Sleeping quarters.—Sleeping quarters for children should be healthful. If tents are used, they should be on wooden platforms raised from the ground. They should be completely weatherproof and should be adequately ventilated. For young children cabins or cottages are preferable to tents. Sleeping quarters should not be crowded. A list of minimum standards for organized camps, as published by the National Park Service,[3] includes the recommendation of the United States Public Health Service that "cots shall be spaced 6 feet between the side rails and 4 feet between bed ends." These are minimum requirements. More space is desirable.

Food.—The food that a child receives at camp is very important for his general health. Someone with training in dietetics should be responsible for planning the camp menus. The food should be simple, and the meals should be well balanced and wholesome. A supply of pasteurized milk should be available; raw milk should not be used either for children or adults. Fresh fruits and vegetables should be used liberally. The wholesomeness of the food served to the children is dependent not only on the actual food selected but also on the health of the persons preparing it. All individuals handling the food served at a children's camp should be known to be free from communicable disease at the beginning of the camp season, and their health should be under the supervision of the camp physician throughout their period of attendance at the camp.

The kitchen facilities of the camp should include adequate equipment for refrigeration of food and for sterilization of eating utensils.

Health examination.—The physical condition of each child on his entrance at camp must be known. A well-run camp requires the parents to submit the results of a health examination made not more than a week before the child arrives at camp. Any special health problems of the child should be brought to the attention of the camp director. Conditions, such as chronic sinusitis, a weak heart, or any other abnormality that would call for a curtailment of activity, must be well understood by the camp director. Knowledge of allergy or food sensitivity in a child will help the camp authorities to provide for this allergic child's comfort. Children should be immunized against diphtheria and smallpox before entering camp if they have not had these inoculations within a reasonable period. In some camps immunization against typhoid fever is recommended. It is wise to see that a child's teeth are in good repair before he goes to camp so that he will not need dental work done during the camp season.

Medical care.—In addition to insuring conditions in the camp that are conducive to the health of the children, a well-run camp has medical service readily available at all times. A camp physician should be in residence at the camp or within easy reach. This physician should have experience with the medical problems of children. Internes or medical students are not a satisfactory substitute for an experienced physician. Every camp should also have a nurse in residence. She should be a graduate of an approved school of nursing and should have had nursing experience and be familiar with the problems of health supervision of children.[4]

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[2] Id.

[3] Digest of Laws Affecting Organized Camping. Appendix 1. National Park Service, U. S. Department of the Interior, Washington, 1939.

[4] The American Academy of Pediatrics recommends that the physician have 5 years of experience in medical practice and that the nurse have 3 years of experience in graduate nursing.

The camp physician should inspect every child on arrival and make physical examinations of all children admitted to camp within 48 hours of their arrival. He should check his findings against those of the family physician. Such examinations are necessary if the camp physician is to be responsible for the child during his stay at camp. Periodic examinations should be made of any children with abnormal conditions.

The health routines of the camp are the responsibility of the camp physician. It is essential that there be some efficient daily routine whereby children with coughs or "sniffles" are promptly isolated and treated in a suitable infirmary. Examinations should be made by the physician, not by counselors. Counselors are seldom competent to bear the responsibility of such examinations.

Either independently or in collaboration with the State health department, the camp physician is responsible for the sanitary inspection of the camp. He must examine the food handlers with special reference to typhoid fever, tuberculosis, and syphilis. He must investigate the water supply and the milk supply and see that the disposal of sewage and garbage is satisfactory. He must see that the food is adequately refrigerated and that the eating utensils are sterilized after each using.

The physician must, of course, be available to render medical and surgical care to campers and to the staff. He must see that there is adequate provision for care of sick individuals, including provision for isolation. He should have access to the facilities of a good hospital in case of need.

The physician should be consulted with reference to planning the camp program so as to insure adequate rest and relaxation for all children. He should be consulted also with regard to special problems concerning the daily routine for individual children.

The camp nurse must be always in residence to render first aid in the absence of the camp physician. It is her responsibility to see that first-aid kits are available at all times at the water front, the riding area, and on all trips out of campgrounds. She must be available to render nursing care to any sick individuals. In addition she assists the physician in his various duties.

Safety.—Besides care for general health, a good camp must make provision to avoid accidents.

Especially is this needed where swimming is a camp activity. Swimming areas should be well marked and the bottom should be clean, not muddy, and should be free from debris and sharp rocks. There should be no deep holes or swampy spots. The swimming area should not be near any treacherous currents or strong undertow. The head swimming instructor should have received certification as a water-safety instructor and his assistants as senior lifesavers according to the standards of the American Red Cross or other organization with equivalent standards. Some definite routine should be enforced whereby there are periodic checks on every camper during the swimming period. One of the lifesavers should be on duty at the water front whenever any camper is permitted there.

Horseback riding has been the source of many severe accidents at camp because of lack of proper supervision. The riding teacher, in addition to training in cavalry school or riding school, should have had some experience and training in the care and guidance of children.

Summer camps should be supplied with fire-fighting equipment, because the danger of fire is great. Cabins and tents are inflammable and in most camps it is difficult to get large supplies of water quickly. There should be an adequate number of fire extinguishers and fire buckets, and the children and staff should have instruction in fire drill.

Counselors.—A good camp for children requires good counselors. One counselor for every five children is desirable. The number of children supervised by each counselor may vary with the age of the children, however. Counselors should be young adults over 20 years of age with several years of experience in camp work or in teaching. Counselors in their teens may be competent in various skills, but their lack of experience with children can have serious consequences. Such counselors are likely to look upon their summer work as an inexpensive vacation rather than as a responsible job.

The Camp director—The camp director is the most important part of a summer camp. He *is* the camp. His philosophy will dominate the camp and to a very large measure will be responsible for the health and welfare of the children in his care. It is essential that he be the kind of person suitable for a leader of children. He must be a person of honor and of integrity, sympathetic toward children and understanding of their needs, a person to whom every one of the children and every one of the counselors can look for guidance and help in daily routines or in an emergency. He should be a person known among educators for his ability as an educator.

Public-Health Nursing in New Mexico

NOTE.—The following excerpts from monthly narrative reports made by public-health nurses in the New Mexico Department of Public Health during the winter of 1940–41 indicate some of the social, economic, and geographic factors that exist in parts of the Southwest. They were made available to the Children's Bureau by Mrs. Fannie T. Warncke, director of public-health nursing, New Mexico Department of Public Health.

The variety of demands made upon a public-health nurse working in rural counties such as these is touched upon. Not only is nursing care for a sick child essential, but other services must be provided for a family if the mother is not well and the children must be fed. Communities frequently must be given leadership in developing and coordinating local facilities for the welfare of their members. In these and other problems the public-health nurse is concerned.

The excerpts quoted were not selected to describe the kind of care a nurse gives to a sick child, or the steps taken to assure medical care, or the methods used in helping a family of seven to plan for "adequate calories, vitamins, and so forth, on $5 per week" but rather to illustrate the local situation in which the public-health nurse functions.

In addition to narrative reports and activity reports, the nurse keeps regular service records for every family served. On these is recorded information about the kind of nursing service given and about the educational devices that the nurse is using to help families help themselves. A. T. B.

SAN MIGUEL COUNTY

Early this month Mrs. M—, a prenatal patient 15 years of age, came to the health department Friday afternoon. Her midwife had referred her to the prenatal clinic, and although she and her husband had started at 6 o'clock in the morning it had taken 8 hours to travel the 33 miles to town in a truck equipped with chains. She was, of course, given a complete examination, literature, advice, and a card to notify the health department when the baby was born.

Three days later the husband telephoned to say his wife had been delivered at 5 a. m. and at 9 a. m. the placenta was still retained. Mr. M—, on horseback, met the public-health-nursing consultant in maternal and child health and the nurse-midwife consultant 3 hours later at the turn-off from the main road. By skillful driving another mile was covered before the car sank down to the running board in mud. The rest of the distance was covered on foot and on horseback. Mrs. M— was found in fair condition, and the placenta was removed manually. She explained that soon after the baby was born she had asked her husband to mail the notification card, but the untrained midwife who delivered her had said, "No, wait, we might need them yet."

* * *

In December 1939 we (the consultants) were looking for a small settlement of four houses, supposedly behind Starvation Peak, called Rincon de Bernal, which we had never heard of before. We had a birth-certificate call-slip in our hands for a baby born 2 weeks before. After what seemed like aimless wanderings through a prairie-dog town we found Rincon de Bernal. In the second house was baby G—, surrounded by two brothers and six small cousins. His eyes were swollen and shut tight with caked pus. The physician immediately took two smears from the eyes and nose. One was mailed to the State laboratory and one was brought back to the office and examined by the physician, who made a diagnosis of diphtheritic conjunctivitis. As rapidly as we could we retraced the many miles to Rincon from Las Vegas. The physician gave the baby antitoxin, and the brothers and cousins were given protective inoculations.

Smears were taken from everyone in the household, and it was discovered that the baby's maternal grandmother was the carrier. The health officer and the public-health nurse made innumerable visits in order to teach isolation, the need of quarantine, communicable-disease technique, how to carry out the physician's orders, and how to prevent the other children from contracting diphtheria.

To sum up, baby G—'s eyes got well, although scar tissue remained; no other children contracted the disease; and the grandmother is no longer a carrier.

Chaves County

Considerable time was spent during the month in organizing midwife classes. I found very inadequate provisions for delivery service for needy patients in the community. Grandmothers, husbands, and other unprepared relatives were often called upon to provide delivery service in an emergency. The few experienced midwives available were poorly prepared for their work. Members of the local medical society were keenly interested in prospects for procuring instructions for midwives and practical nurses in order to provide intelligent assistance to physicians at delivery service and better midwife service for indigent persons. A wholehearted response to the invitation to take instruction came from all groups, including the Spanish-American. Midwives, too, seem very appreciative of the instruction.

Much time was spent in organizing a prenatal clinic in X—. Conferences were held with two physicians and with lay persons who acted as clinic assistants, regarding procedures and equipment. The cooperation obtained from all who participated in the first clinic was most heartening.

Eddy County

Each year the merchants of C— give gifts to honor the first baby born on the first day of the new year. This year the honor and joy fell to one nameless little Mexican born into the poorest of homes—an old broken-down, windowless shack. His mother beamed upon the gifts awarded her newborn, such things as an electric bottle warmer (though they haven't enough kerosene for the lamp), 5 gallons of gasoline (and they possess no car), a week's diaper service (and she has just 12 diapers), and last but not least—the thing which his mother just loves—the outdoor picnic grill!

Grant County

A trip was made into a mountain district to investigate the case of a child with measles. Snow, ice, and wind made it almost impossible to reach the home, and had it not been for the road being too narrow to turn around on, I should have given up. I found the mother and her two children very ill. The father in this family died 2 years ago. The mother was about to get out of bed and attend to the outside chores, although she had a very severe case of influenza. Before I left I had filled the wood box, brought in a supply of water, fed the hens, and gathered the eggs. When it seemed that all outside chores were done, I settled down to the nice warm duty of preparing soup for the sick. But one of the children refused to eat until her dog had been fed, so out to the barn I went with dog food. Four hounds met me with grateful whines and then I found a big surprise in the nature of six puppies all cuddled up in a corner of the barn, and, being a dog lover, I took more time to find bedding for them. After a time the family had been fed, and I started away with the very grateful hounds chasing my car.

Curry County

The nurse was asked by a father to figure a budget of food-buying for a family of two adults and five children, 15 months to 9 years of age. He wants adequate calories, vitamins, and so forth on $5 per week. A gallon of milk is given to them every other day. The mother has a mental age of about 10 years.

The one bright spot was the organization and conduct of a new infant and preschool clinic in January. Many of the mothers were delighted to have such a service offered them. One mother, who had been a rural school teacher before her marriage and had helped conduct clinics in the school, remarked, "I have wished many times since I have become a mother that I could attend one of these clinics. When I see my family physician it is because of illness and I am so consumed with the immediate problem that I cannot remember to ask the many questions about behavior problems, habits, and so forth, which occur during normal periods."

HIDALGO COUNTY

The 2 well-baby clinics held in Lordsburg were well attended this month. It was encouraging to have 7 patients come to our prenatal clinic. Two of them came a distance of more than 40 miles. One of our prenatal patients living at Playas lost her last 4 babies less than 24 hours after birth. Several attempts in the past have failed to bring this patient to the clinic. When she did come serological tests were made on the patient and her husband, the results of which were positive.

These patients are anxious to secure treatment. They attended our venereal-disease clinic this week, bringing with them their two children for blood tests. The husband is employed as a section hand and does not believe he will be able to attend the 1 o'clock clinic but says he will bring his wife to Lordsburg after work the night before and return for her the next night. An attempt will be made to help this family make arrangements whereby the husband may also secure treatment.

* * * *

One of the babies under health-department supervision died of pneumonia 2 weeks before he was 1 year of age. The malnourished condition of the child was probably a factor in his developing pneumonia. The mother had had a great deal of trouble with the baby feedings; being employed most of the time, she left the care of the baby first to one person and then to another. Instead of following the instructions of one physician long enough to obtain desirable results, she frequently changed physicians. The week following this baby's death the mother gave birth to another child. We hope to be able to educate this mother to the value of more regular and efficient care for this baby.

* * * *

In a consolidated high school the Women's Extension Club sponsored a school-lunch program last year with much protest from the school board. This year they had raised more funds and would have continued the lunch project, but the school board would not give consent. The main objection was that in serving free lunches to children, "we would be teaching them to depend on the government for too much, also we members of the school board went to school and didn't have free lunches, and the trend is to make it too soft for children in this age."

Many children who attend this school live in the country and have to leave home before 7 a. m. and do not return until 6 or 7 p. m. Many do not have a good, wholesome meal at any time.

LINCOLN COUNTY

The home-economics teacher asked for two demonstrations for her home-nursing class—one in bed making and the other on bathing a patient in bed. The material presented was such that the class members could assist; the atmosphere was informal, and discussion was free.

During the month the pamphlet "The School Lunch and Related Activities" has been emphasized so that the hot-lunch project shall be of the greatest possible benefit to those centers where it is operating. Through the hot lunch the teachers and the parents have opportunities to teach boys and girls along specific lines which will give them an understanding not only of proper foods but of healthful living.

SAN MIGUEL COUNTY

The consultants are firm believers in public-health education and in Dr. John Dewey's philosophy of learning by doing—that in a situation where teacher and learner participate the situation is changed and the participants change and grow.

This was beautifully illustrated in Barranco y La Fragua, two small communities on the banks of the Pecos River, 35 miles from Las Vegas. These two communities are built on the ruins of the Indian pueblos, with the original irrigation ditch built by the Indians still functioning—two communities hardly touched by any culture other than their own.

On one of the days when we were working in the communities making infant, preschool, and prenatal calls we mentioned here and there how cold it was for the school children to walk 6 miles back and forth to school and carry their lunch and what a blessing it would be if there were a hot-lunch program in the school. Before the day was over, people were asking the nurse, "How can we have a hot-lunch project here?"

We explained how they first needed an active, strong committee, representative of the mothers, fathers, and school who would assume leadership. This was formed the same week! The committee worked in the small villages with the families, while we arranged for various agency representatives to attend the "junta" 10 days later and explain how hot lunches could be obtained. At the meeting school children, parents, teachers, and representatives of the Farm Security Administration, San Miguel County Health Department, Work Projects Administration, and Department of Public Welfare were present. Short talks were given by the latter with much discussion from the floor. Many of the people were slow to grasp the opportunity; the committees were discouraged, but we explained that to the degree the committee forged ahead would the project become a reality. Two weeks later the hot-lunch program was established and functioning.

BOOK NOTES

National Tuberculosis Association The National Tuberculosis Association in connection with its 1941 Early Diagnosis Campaign held during April points out that "A good X-ray is your doctor's best aid for finding early tuberculosis." Program materials available from the National Tuberculosis Association (1790 Broadway, New York) include circulars, posters, and three pamphlets (The Chest Roentgenogram, Half a Million People, and Let Us Look at Facts).

The Place of Child Health in a Tuberculosis Program, prepared by Louise Strachan, has been issued by the National Tuberculosis Association (New York, 1940, 32 pp.) to serve as a manual of services and agencies concerned with child health in the home, the school, and the community, in relation to a tuberculosis program.

Cerebral Birth Palsy Bibliography The National Society for Crippled Children has issued A Cerebral Birth Palsy Bibliography, compiled by J. Thomas McIntire, psychologist, New Jersey State Crippled Children Commission (*Institutional Bulletin* No. 30, February 1941, National Society for Crippled Children, Elyria, Ohio, 38 pp. 25 cents). This contains more than 600 references, ranging from technical articles on operative treatment to articles advising parents on the general needs and training of the child with cerebral palsy. Materials published through December 1940 are included.

A BIBLIOGRAPHY OF HUMAN MORPHOLOGY, 1914-1939, by Wilton M. Krogman. University of Chicago Press, Chicago, 1941. 385 pp. $3. Processed.

The lists of references that make up this volume include books, periodical articles, and reports in Danish, Dutch, French, German, Italian, Latvian, Norwegian, Polish, Portuguese, Rumanian, Russian, Spanish, and Swedish, as well as in English. The lists are classified by subjects under 16 headings. The subject "Growth" has 15 subheads, among which are skeletal age changes, growth and diet, and foetal growth. An authors' index facilitates the use of the material.

BIRTH ATLAS. Published by Maternity Center Association, 654 Madison Ave., New York, 1940. $3.50.

The Birth Atlas consists of reproductions of 24 life-size sculptures of fertilization, growth of the fetus, stages of labor, and involution of the uterus. These sculptures were originally planned as a means of giving to students studying reproduction a concept of the third dimension, a concept difficult to get from flat drawings, but essential for an understanding of the anatomy and physiology of the female organs of reproduction.

The sculptures are the combined work of Dr. Robert L. Dickinson and Abram Bilskie who consulted a large number of X-rays, some of which were taken especially for the study.

The sculptures were used first as an exhibit of the Maternity Center Association at the New York World's Fair. The photographs were made by DeWitt Ward Studio and have been reproduced in life-size pictures and bound in a folio that can be used to hold the pictures as an exhibit for lecturing purposes.

D. V. W.

ARE WE WELL FED? A report on the diets of families in the United States, by Hazel K. Stiebeling, U. S. Department of Agriculture, Miscellaneous Publication 430, Washington, 1941. 15 cents. 28 pp.

This pamphlet presents graphically some of the findings of a study made by the Division of Family Economics of the Bureau of Home Economics, of the United States Department of Agriculture. It emphasizes the need for the increased use of protective foods and directs attention to the many millions who would profit by such a practice. It shows that among rural families as well as urban families, among the well-to-do as well as among the poor, are found those who are inadequately fed. In general, though, the diet of the farm family includes more of the protective foods than that of the village and urban family having the same income. In general, too, as the income rises the amount expended for protective foods is increased. Briefly, the pamphlet states that in all classes of society there are those whose lives might be bettered by improving their diets.

National Conference on Nutrition for Defense

May 26–28, 1941

For the purpose of mobilizing scientific, educational, health, and welfare activities as they relate to nutrition, the President of the United States has called a National Conference on Nutrition for Defense to meet in Washington, May 26 to 28, 1941. Paul V. McNutt, as Coordinator of Health, Welfare, and Related Defense Activities, is charged with organizing the conference and with calling to it men and women who have given much time to studying nutrition problems and who are experienced in dealing with them.

Children's Bureau Nutrition Leaflets

Free copies of the leaflets listed can be obtained from the Children's Bureau, United States Department of Labor, Washington, D. C.

WELL-NOURISHED CHILDREN. Folder 14.[1]

THE HEALTHY, WELL-NOURISHED BABY; birth to 1 year. Folder 16.

THE HEALTHY, WELL-NOURISHED CHILD; 1 to 6 years. Folder 17.

THE HEALTHY, WELL-NOURISHED CHILD; 6 to 16 years. Folder 18.

FEEDING YOUR BABY; first year. Folder 20.

YOUR YOUNG CHILD'S HEALTH; 1 to 6 years. Folder 21.

YOUR SCHOOL CHILD'S HEALTH; 6 to 16 years. Folder 22.

THE NOON MEAL AT SCHOOL. Folder 23.

YOUR CHILDREN'S FOOD AND THE FAMILY POCKETBOOK. Folder 24.

SUBSTITUTES FOR THE SUN. Folder 25.

EAT THE RIGHT FOOD TO HELP KEEP YOU FIT.[1]

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[1] In cooperation with Bureau of Home Economics, U. S. Department of Agriculture.

• CHILD WELFARE • SOCIAL SERVICES • CHILD GUIDANCE •

ANNUAL REPORTS OF FOUNDATIONS

Rockefeller Foundation Six major fields received appropriations from the Rockefeller Foundation in 1940, states Raymond B. Fosdick, president, in A Review for 1940 (Rockefeller Foundation, New York, 1941, 64 pp.). The field of public health received $2,750,000, natural sciences $2,200,000, social sciences $1,500,000, medical sciences $1,300,000, humanities $1,075,000, and rural reconstruction in China $200,000.

Mr. Fosdick reports that it is no longer possible under the regulations of the United States Treasury Department to make payments on appropriations for work in the occupied areas of Europe, including Norway, Belgium, Holland, Denmark, France, and Rumania. Moreover, as the situation on the Continent of Europe has deteriorated, a large number of universities and institutes have been closed and many others "are working under conditions scarcely tolerable." The necessity of protecting the careers of scholars unable to continue work in their native lands has given rise to two Foundation programs. Under the placement program, begun in 1933, 122 scholars have been assisted to find places in the United States. Under the emergency rescue program, undertaken in 1940, the Foundation and the New School for Social Research have assisted 56 refugee scholars representing 11 nationalities. The Foundation is also responsible for working out a plan for training British medical students in medical schools of Canada and the United States.

Other features of the work of the Foundation reported are the development of an experimental influenza vaccine; the establishment of a School of Public Health in the University of Michigan through grants from the Rockefeller and W. K. Kellogg Foundations; and a grant for the construction of a giant cyclotron for atomic research at the University of California.

Carnegie Corporation of New York The Carnegie Corporation of New York has issued the Report of the President and of the Treasurer for the Year Ended September 30, 1940 (Carnegie Corp. of New York, 522 Fifth Avenue, New York, 183 pp.).

This report records the decision of the Board to enable other Carnegie trusts, notably the Carnegie Foundation Pensions, and the Carnegie Institute of Washington, to fulfill their obligations in spite of the continual low-interest rates, and the consequent curtailment by about 25 percent of the funds available for appropriation during 1940–41.

Carnegie Endowment for International Peace The Carnegie Endowment for International Peace has issued its Annual Report for 1940 of the Division of Intercourse and Education, by Nicholas Murray Butler (Carnegie Endowment for Int. Peace, 405 West 117th Street, New York, 60 pp.). Most of the report is devoted to the administration of the division in the United States, but there are brief sections on its work in Latin America, in the Orient, and also in Europe, where "the continuing spread of the war has farther and inevitably interrupted parts of the work."

Commonwealth Fund report The Twenty-second Annual Report of the General Director of the Comonwealth Fund, for the year ended September 30, 1940, has been received (41 East 57th St., New York, January 1941, 73 pp.). It includes a review of developments during the year, a sketch from the field, and a list of scientific papers published.

PAN AMERICAN NOTES

Mexico Ratifies Convention for Promotion of Inter-American Cultural Relations

The announcement that Mexico has ratified and deposited the Convention for the Promotion of Inter-American Cultural Relations signed at Buenos Aires, December 23, 1936, brings to 15 the number of American republics that have agreed to carry out the terms of the Convention, the provisions of which are administered by the Department of State.

Up to the present time the Convention, which provides for the annual exchange of two graduate students or teachers and the biennial exchange of professors by the United States and each of the other ratifying republics, has been adhered to by Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, the United States, and Venezuela. The Convention was originally signed at Buenos Aires by each of the 21 American republics.

Eighth Pan American Child Congress to Meet in United States

After the postponement of the Eighth Pan American Congress, which was to have been held in Costa Rica in October 1939, the International Council of the International American Institute for the Protection of Childhood, with headquarters in Montevideo, Uruguay, and the Governing Board of the Pan American Union recommended that the Congress be held in the United States. This action is in accordance with the plan approved by Costa Rica, which hopes to entertain the ninth Congress.

This proposal received the approval of the Department of State and of Congress, and the deficiency appropriation bill signed by the President of the United States on April 1, 1941, made provision for funds for holding the Congress. As soon as the date has been determined, the Department of State will send official invitations to other American Governments to participate in the Congress, which will be held in Washington, D. C.

MEMORIA CORRESPONDIENTE EL AÑO 1940 presentada al Consejo Internacional por el Director Dr. Roberto Berro. (Report for 1940 presented to the International Council by the Director, Dr. Roberto Berro.) Instituto Internacional Americano de Protección a la Infancia,[1] Montevideo, Uruguay, 1941. 11 pp.

The report for 1940 of the International American Institute for the Protection of Childhood presented by the Director, Dr. Roberto Berro, to the International Council administering the Institute, at its regular annual meeting February 14, 1941, indicates that the Institute has entered new fields of action. According to a previous agreement, a technical commission was sent by the Institute to Paraguay to discuss with the public-health authorities plans for a study of infant mortality in that country. This is the first attempt by the Institute to engage in field studies. Plans are pending for a similar study in Bolivia.

At the suggestion of Chile, Uruguay, and the Pan American Union the Institute has considered measures by which the governments of the Latin American countries could aid children from Europe seeking safety in the Americas. A report recommending such measures was presented by Professor Emil Fournié, Chief of the Institute, and approved by the International Council of the Institute.

Another new subject studied in 1940 was the possibility of coordinating the work of the Institute with that of the Pan American Union and of the Pan American Sanitary Bureau.[2]

The Institute continued during 1940 the publication of its quarterly bulletin. It answered inquiries from various countries of Latin America and received a large number of additions to its library. The Institute's financial statement for 1940 is also given in the report.

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[1] The International American Institute for the Protection of Childhood, with headquarters in Montevideo, was established in 1927 in compliance with a resolution passed at the Fourth Pan American Child Congress in Santiago, Chile, in 1924. The purpose of the Institute is to serve as a center of study, information, and advice on matters pertaining to child welfare in the 21 countries of the Pan American Union. At the end of 1940, 14 of these countries, including the United States, were members of the Institute.

[2] Representatives of the Pan American Union and of the Pan American Sanitary Bureau attended the meeting of the Council at which this report was presented.

BOOK NOTES

Social Work Year Book, 1941; a description of organized activities in social work and in related fields, edited by Russell H. Kurtz. Russell Sage Foundation, New York, 1941. 793 pp. $3.25.

In response to widespread suffering caused in the last decade by the economic depression, social work, both public and private, has changed greatly. The six issues of the Social Work Year Book, appearing every second year since 1930, cover these years of transformation in agency program, volume of work, and emphasis.

The Social Work Year Book, 1941, like its predecessors, is divided into two parts, the first, more than three-fourths of the volume, consisting of topical articles by specialists. The second part contains directories of 440 national agencies, governmental and private, and 592 State agencies, public and private. The current edition is physically larger by 63 pages than the 1939 issue and is more comprehensive because of the addition of eight new topical articles, including White House Conferences (a summary of the four conferences), Social Workers' Organizations, Old Age, Railroad Workers' Insurance, and Civic and Fraternal Organizations. Other articles, notably Behavior Problems, have been broadened in scope.

Almost all the topical articles as, for instance, The Family, naturally deal partly with the interests of children, but outstanding articles on this specific subject—services to children—appear under the titles: Aid to Dependent Children, Behavior Problems, Boys' and Girls' Work Organizations, Child Welfare, Crippled Children, Juvenile and Domestic Relations Courts, Maternal and Child Health, Vocational Guidance, White House Conferences, and Youth Programs.

What the High Schools Ought to Teach; the Report of a Special Committee on the Secondary School Curriculum. American Council on Education, Washington, D. C., 1940. 36 pp. 25 cents.

This booklet is the result of the deliberations of a special committee of educators appointed by the American Youth Commission to prepare a brief report on the major needed changes in the curriculum of the American secondary school.

The report takes up various subjects which the committee believes should be taught in high school. The first subject discussed is reading. The reasons why poor reading in the high school is a common handicap are pointed out and suggestions made for improving the situation.

The place of work as a specific unit in the high-school curriculum is the next subject taken up. The belief is stated that work, some of which will have to be arranged outside the school, should be given the right of way. The objectives of a work unit in the secondary school are pointed out and procedures suggested for carrying out those objectives.

The third subject concerns the place of the social studies in the secondary-school curriculum. It is stated that young people should be able to form wise judgments based on knowledge of the facts on a long list of topics, including "housing, conservation of natural and human resources, community planning, cooperatives, pressure groups and their methods of influencing legislation, the stock exchange, corporations, labor organizations, the industries of the nation, various forms of municipal government, governmental services such as those of the Departments of Agriculture, Commerce, and Labor, the origin and nature of money and systems of exchange, international relations, consumers' needs, and investments."

Recommendations are made for including in the high-school curriculum a course in personal problems of physical and mental health and family life. Methods of instructions in these subjects are suggested.

D. H. F.

Democracy's Challenge to Education, edited by Beulah Amidon. Farrar & Rinehart, New York, 1940. 263 pp. $1.50.

This is a symposium of 20 articles dealing with various aspects of the subject. With the exception of a chapter reviewing the Regents' Inquiry Into the Character and Cost of Public Education in the State of New York, the present volume is a reincarnation of a special number of *Survey Graphic* published in October 1939.

• CHILD LABOR • • YOUTH EMPLOYMENT • • VOCATIONAL OPPORTUNITIES •

Connecticut Experiments With Certificates of Age for Children in Agriculture

Although child labor has been decreasing in manufacturing plants, more and more is heard of the pathetic plight of youngsters in "factories in the fields."

Last summer an interesting experiment was tried in Connecticut to keep children under 14 years of age out of the tobacco fields. There is no law in Connecticut regulating the employment of children in agriculture during school vacation, so the arrangement between the Connecticut Department of Labor and the Connecticut tobacco growers was on a purely voluntary basis. The growers with large plantations agreed to employ only children who had "certificates of age," issued by the State Department of Education, which showed they were at least 14 years of age. In the tobacco-producing areas the time and the place of issuance of these certificates were called to the attention of children in school before vacation began.

The certificate issued was not a "permit to employ" but was merely a proof-of-age card issued on the form used as a "certificate of age" for older minors employed in Connecticut factories and stores. The only preliminary paper absolutely required by the issuing officer was documentary evidence of the minor's age—a birth certificate from the bureau of vital statistics if obtainable. A statement of "intention to employ," signed by the prospective employer, was also obtained when possible. Neither the school record nor examination of the child by a physician was required for the issuance of this certificate of age for work in agriculture.

A report recently released by the Department of Labor and Factory Inspection in Connecticut, Working and Living Conditions on Connecticut Shade Tobacco Plantations, Summer, 1940, makes the following statement regarding child labor and the effectiveness of these agreements:

> At the suggestion of the Department of Labor, the State Board of Education sent letters to school authorities in 18 towns and cities, requesting them to announce, before the close of school, that certificates of age would be issued to children 14 years of age and over for work on the tobacco fields. Approximately 850 applications were received and 354 certificates issued to children who had secured work. As a result of this cooperation 128 certificates were found on file in the fields. On many plantations certificates had been requested and returned to children. Thirteen children 13 years of age and two 12 years were working on plantations visited. On every field but one there were children of doubtful age who had not been asked for certificates. It was evident that the general practice was to request proof of age only when children appeared to be under 14 years of age.

This "gentlemen's agreement" as to labor standards is definitely an improvement over earlier agreements made from 1932 on, under which tobacco growers agreed to hire workers at least 14 years of age but which included no arrangement for furnishing minors with State certificates of age. A report by the Connecticut Department of Labor of eight farms inspected in 1936 revealed that at that time only one farmer required proof of age.

In view of the growing consciousness in many States that the employment of young children in industrialized agriculture is a serious problem, experiments in the solution of the problem are watched with interest. The most satisfactory solution probably would be the extension of legislation to cover employment of children in "factories in the fields" as well as in industrial establishments, but an agreement to employ no children under 14 years of age and to require certificates of age as proof is a step in the right direction.

Age Certificates for Young Sugar-Beet Workers in 1941

The Children's Bureau in cooperation with the Sugar Division of the United States Department of Agriculture is again making proof-of-age cards available for children working in the sugar-beet fields.

This season the program inaugurated in 1939 (see *The Child*, Vol. 4, Nos. 11 and 12) is to be carried out in Colorado, Idaho, Oregon, Utah, North Dakota, and Wisconsin, in addition to the States included in the 1940 season, Michigan, Ohio, Iowa, Nebraska, Wyoming, and Montana.

State departments of labor and education as well as local school officials are cooperating with the Children's Bureau in making possible this certification program for children in the sugar-beet fields. Its purpose is to aid in bringing about compliance with the 14-year minimum-age standard for work in the sugar-beet fields as set by the labor provisions of the Sugar Act of 1937.

Designation of Louisiana

Louisiana has been designated by the Chief of the Children's Bureau as a State in which State age or employment certificates shall have the same force and effect as Federal certificates of age under the Fair Labor Standards Act of 1938. The designation is effective as of April 15, 1941, for a period ending June 30, 1941.

BOOK NOTES

National Child Labor Committee The Annual Report of the National Child Labor Committee for the Year Ending September 30, 1940, deals with problems in the national arena, enforcement of Federal acts, State legislation, and children working in theatrical employments. Emphasis is laid on the social and economic aspects of the problem of employment of children in agriculture and of children in migrant families and on protective measures that should be taken. The report, by Courtenay Dinwiddie, general secretary, may be obtained in mimeographed form from the National Child Labor Committee (419 Fourth Avenue, New York, 60 pp.).

Child Labor Problems in Agriculture, appearing in *Information Service* (Federal Council of the Churches of Christ in America) for January 11, 1941, is an article specially prepared for this purpose by the National Child Labor Committee. This article brings out the close relationship of child labor in agriculture to problems of general economic welfare.

Occupations for Girls and Women The Vocational Division of the United States Office of Education, Federal Security Agency, has issued Selected References on Occupations for Girls and Women (Misc. 2518, 1940, 56 pp. Mimeographed.). This consists of excerpts from References and Related Information on Vocational Guidance for Girls and Women, and covers the period January 1935 to June 1940.

• *EVENTS OF CURRENT INTEREST* •

Summer Courses Announced

Workshop in community nutrition

The University of Chicago is offering a special workshop course in community nutrition during the second term of the summer quarter:

July 28–Aug. 28	Community and public-health nutrition.

The Children's Bureau of the United States Department of Labor is cooperating by making the services of three staff members available as instructors: Marjorie M. Heseltine, consultant in nutrition, Jessie M. Bierman, M. D., pediatrician, and Marian M. Crane, M. D., pediatrician. The workshop will be under the direction of Lydia J. Roberts, chairman of the Department of Home Economics of the University of Chicago, from whom information can be obtained regarding other instructors, enrollment, academic credit, and expenses.

New York School of Social Work

Two-week institutes for experienced social workers will be given by the New York School of Social Work, Columbia University, as follows:

June 16–27	Social-welfare administration.
July 21–Aug. 1	Psychiatry in social case work; Public relations, publicity and finance; New trends in child placing; and Field surveys in public welfare.
Aug. 4–15	Social work in the national emergency; Administrative supervision in child welfare; Group-work supervision; and Casework supervision.

Information as to admission, credit, expenses, instructors, can be obtained from the New York School of Social Work, 122 East Twenty-second Street, New York.

Sight-saving courses

The National Society for the Prevention of Blindness (1790 Broadway, New York) has announced that it is cooperating with the following colleges and universities in offering, at their 1941 summer sessions, courses for the preparation of teachers and supervisors of sight-saving courses:

June 23–Aug. 2	Wayne University, Detroit, Mich. Director: Margaret Soares, Supervisor of Braille and Sight-Saving Classes, Detroit.
June 23–Aug. 2	Western Reserve University, Cleveland, Ohio. Director: Olive S. Peck, Supervisor of Braille and Sight-Saving Classes, Cleveland Public Schools.
July 7–Aug. 15	State Teachers College, Buffalo, N. Y. Director: Mrs. Winifred Hathaway, associate director, National Society for the Prevention of Blindness.

Details regarding the courses may be obtained from the university or college, or from the director in charge of the course.

Courses sponsored by N. E. A.

The Department of Supervisors and Directors of Instruction of the National Education Association of the United States has announced that it is sponsoring four sets of conferences to take place during the summer:

July 7–19	Teachers College, Columbia University, New York. Subject: How to develop wholesome personality through the school program.
July 7–18	University of Denver, Colorado. Subject: The pupils, the community, and the curriculum.
June 12–July 19	University of North Carolina, Chapel Hill. Subject: Life in the rural community.
July 14–25	University of California at Los Angeles. Subject: Democratic guidance of teachers in the modern school.

The conferences are open to all who are interested in better teaching and instructional leadership—supervisors, teachers, principals, superintendents, directors of instruction, research, curriculum, and teachers of education. Information as to enrollment, academic credit, fees, living arrangements, may be obtained from the Department of Supervisors and Directors of Instruction, N. E. A., 1201 Sixteenth Street NW., Washington, D. C., or from the university giving the course.

University of Michigan Summer-session courses in hygiene and public health are offered at the University of Michigan for a period of six weeks, June 30 to August 9. A variety of courses are offered, of which a maximum of three courses totalling 6 hours may be taken for credit. Full information may be obtained from the Division of Hygiene and Public Health, University of Michigan, Ann Arbor, Mich.

Recent Children's Bureau Publications

Children's Bureau activities reported The report of the Chief of the Children's Bureau, which appeared on pages 126 to 203 of the Annual Report of the Secretary of Labor, Fiscal Year Ended June 30, 1940, has been reprinted separately and can be obtained from the Children's Bureau, United States Department of Labor. In addition to summarizing the work of each division this report covers the administration of the three social-security programs for which the Children's Bureau is responsible and the administration of the child-labor provisions of the Fair Labor Standards Act of 1938.

The Child-Health Conference Suggestions for organizing and conducting child-health conferences are embodied in The Child-Health Conference (Bureau Publication 261, Washington, 1941, 42 pp.). This includes an outline of the functions in connection with child-health conferences of the public-health nurse, volunteer helper, conference physician, nutritionist, dentist, and social worker. There is a section on procedure for mother and child visiting the conference and one on record forms and record keeping.

Standards for care of children coming to the United States for safety Care of Children Coming to the United States for Safety Under the Attorney General's Order of July 13, 1940, is the title of a bulletin (Bureau Publication 268, Washington, 1941, 28 pp.), containing standards prescribed by the Children's Bureau for care in family homes and in groups, standards for child-care agencies, care in reception centers, and medical care of the children.

Information Exchange

A new Information Exchange is being set up in the United States Office of Education, Federal Security Agency, to act as a clearing house for ideas and materials on education and national defense. The official announcement states that educational and civic organizations, administrators, teachers, and laymen are invited to tell the Office of Education what kinds of material they would like to have available through the exchange; report new developments in their work, especially those connected with national defense; and send pertinent materials at once to the exchange.

The exchange will prepare selected materials for circulation on a loan basis in the form of originals, reproductions, digests, bibliographies, and so forth. A catalog describing the materials available will be distributed widely. There will be no fees. Materials will be sent on request to educators, students, libraries, civic organizations, club leaders, youth groups, and others.

U S GOVERNMENT PRINTING OFFICE 1941

CONFERENCE CALENDAR

June 1–7 National Conference of Social Work. Sixty-eighth annual session, Atlantic City, N. J.

June 2–5 International Association of Public Employment Services, Denver, Colo. Chairman, Program Committee: Mr. W. F. Gow, Department of Industrial Relations, Montgomery, Ala.

June 2–6 American Medical Association, Cleveland, Ohio. Chairman, Hotel Committee: Dr. E. F. Kieger, 1604 Terminal Tower, Cleveland.

June 5–9 National Conference of Jewish Social Welfare, Atlantic City, N. J.

June 16–21 National Society for Crippled Children of the United States of America. Third annual institute, Chicago, Ill. Permanent headquarters: National Society for Crippled Children, Elyria, Ohio.

June 19–25 American Library Association. Sixty-third annual conference, Boston, Mass.

June 20–24 American Association on Mental Deficiency. Salt Lake City, Utah.

June 22–26 American Home Economics Association. Thirty-fourth annual meeting, Chicago, Ill.

June 23–25 Masonic Homes Executives Association of the U. S. A. Eleventh annual conference, Dousman, Wis.

June 29–July 3 National Education Association, Boston, Mass. Information: N. E. A., 1201 Sixteenth Street NW., Washington, D. C.

July 6–11 National Federation of Business and Professional Women's Clubs. Sixth biennial convention, Los Angeles, Calif.

July 8–12 Association for Childhood Education. Forty-eighth annual convention, Oakland, Calif.

July 13–18 American Physiotherapy Association. Twentieth annual convention, Asilomar, Calif.

Aug. 10–13 International College of Surgeons, Mexico City, Mexico.

Sept. 15–21 Second Inter-American Congress of Municipalities, Santiago, Chile.

UNITED STATES DEPARTMENT OF LABOR
Frances Perkins, Secretary

CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

The Child is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries.

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives The Child.

The Child is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to the editor, The Child, Children's Bureau, United States Department of Labor, Washington, D. C.

The Child is for sale by the Superintendent of Documents, Washington, D. C., at $1 a year; foreign postage, $0.50 additional. Single copies are 10 cents each. Subscription orders should be addressed to the Superintendent of Documents, Government Printing Office, Washington, D. C.

the CHILD

Monthly Bulletin

AT THE TRI-COUNTY CHILD GUIDANCE CENTER

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

MAY 1941

U. S. [illegible] OF DOCUMENTS
JUN 30 1941

THE CHILD

MONTHLY BULLETIN

Volume 5, Number 11

May 1941

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The Children's Bureau does not necessarily endorse or assume responsibility for the statements or opinions of contributors not connected with the Bureau.

• BIRTH • GROWTH • CHILD HEALTH •

Racial Aspects of Maternal and Child Health[1]

By Katherine Bain, M. D.

Director, Division of Research in Child Development, U. S. Children's Bureau

FIRST-HAND knowledge of the health problems of Negro patients both in clinics and in private practice, and also some experience with Oriental patients, is the basis for the statements made in the present paper. So far as possible these statements have been substantiated by reference to the medical literature, but, especially in regard to minority groups other than the Negro, the gaps in the literature are surprising.

There are in continental United States about 12,000,000 Negroes, some 300,000 Indians, and more than 250,000 Orientals. If Alaska, Hawaii, and Puerto Rico are included, the numbers are even larger. Since the Mexicans in the United States also have special health problems, this nationality group of about 1,500,000 is included in this report. Together the nonwhite races and the Mexicans make up about 11 percent of the population.

The well-being of such a vast number of people is and should be of great importance to us. What is the health of these people? How does it compare with the health of the rest of the population? Are there racial differences?

The American Negro

At birth and at each age level the expectation for life of the Negro is markedly less than that of the white person. The Negro in 1931 had the expectation of life that the white person had in 1901 (*1*).

In 1930 (these figures are not yet available for 1940) the death rate for Negroes (18.0) was 82 percent higher than the death rate for white persons (9.9). The Negro city dweller had a death rate almost double that of the white city dweller. This is particularly significant in view of the huge migration of Negroes to the cities. Between 1910 and 1930, 1,500,000 Negroes moved from rural into urban areas. The high mortality rates hold true for all ages and for both sexes (*2*).

The Negro mother has less chance of surviving childbirth than the white mother, the maternal death rate for Negro women (90) being more than double the rate (44) for white women for the period 1936–38. A Negro baby has less chance of being born alive, the stillbirth rate for the Negro being more than twice that for the white race. If he arrives alive the Negro baby does not have the same chance of surviving the first year. In every State where there are 500 or more Negro live births per year, the mortality rate is higher for the Negro than for the white infant, and in one State the rate for Negroes is twice as high (*3*).

The great killer among Negroes as a whole is tuberculosis. The Negro death rate from tuberculosis is more than three times as great as that of the white population (*2*). For males between 10 and 14 years, the Negro rate is 11 times that of the white race (*4*). Tuberculosis is called the great white scourge, but in the United States it is the great black scourge.

For the incidence of syphilis almost any figure desired can be found in the literature. One looking for extreme figures can find data that show syphilis to be alarmingly prevalent, but it is also possible to find figures which indicate that the frequency of syphilis among Negroes is far lower than many have supposed. One county survey shows that 40 percent of the Negroes are infected; another, less than 10 percent (*5*). The Army figures for the period of the World War, 1917–18, gave the syphilis rate as 6.5 percent for Negro and 1.3 for white soldiers. Figures based on cases under treatment in the general population indicate that the rate for Negroes is approximately twice as high as that for white persons. Syphilis in the Negro race, as in the white, raises the stillbirth rate, the rate of premature births, the infant mortality rate, and the death rate from cardiac disease.

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[1] Paper given at Southwest Regional Conference of Child Welfare League of America, St. Louis, Mo., November 7, 1940.

For certain other diseases—pneumonia, influenza, heart disease—the incidence and mortality are greater among Negroes than among white persons (*4*).

All this goes to show that there are differences in health among racial groups in the United States. Why should these differences exist? There are two possible explanations: First, constitutional or physical differences on a hereditary basis; and second, environmental factors affecting health that are not operating equally for all groups. Take, first, hereditary difference in constitutional make-up. Let no one think that racial difference in susceptibility to disease implies "inferiority." There are certain sex differences in incidence of disease or abnormalities. Boys more frequently than girls have pyloric stenosis (a condition in which the opening from the stomach of an infant is too small) (*6*) and intussusception (a type of intestinal obstruction occurring in infancy) (*7*), and develop more frequently that clinical entity known as allergy. None of these sex differences means sex inferiority or superiority. The same holds true for racial differences, that is, for the few racial differences that are known to exist.

The Negro's susceptibility to tuberculosis and to respiratory diseases has long been used as evidence of "inferiority." The smaller lung capacity or so-called "tropical lung" of the Negro has been given as one explanation. Certainly the type of tuberculous infection seen in the Negro differs from that seen in the white person. The Negro has a more florid, fulminating type (*8*). Tuberculous meningitis is common among Negroes. Tuberculosis of the eyes is relatively rare among white children, but very frequent among Negro children.

The type of pulmonary tuberculosis found in the Negro today resembles that found among white persons a number of years ago. Perhaps this comparison reveals the reason for the Negro's so-called lack of resistance to tuberculosis, as any race or people coming in contact with a new infection is particularly susceptible to that infection. Immunity is built up by generations of contact. Tuberculosis proved a tremendous scourge to the American Indian as well as to the American Negro when introduced by the white race. There is evidence that the Negro, as the white man did before him, is gradually acquiring a higher degree of immunity. That tuberculous infection in the Negro produces a high state of allergy without a corresponding state of immunity is true. That this is the main cause of the high death rate is *not* true (*9*). Though a racial difference exists, its main application is in environmental factors.

What other diseases show differences that can be attributed to constitutional differences in races? Rickets might be counted as one. Rickets is much more severe in colored babies than in white babies in this country (*10*). Is this racial or environmental? Heavily pigmented persons probably absorb less of the antirachitic radiation than lighter-skinned people, it is true, but rickets is essentially unknown among Negroes of the West Indies, where sunshine is abundant. Italians, taken out of their native sunny climate and transplanted to New York, have almost as high an incidence of rickets as Negroes. Race itself is probably not the most important factor. Environmental factors must be held responsible.

The diet of the Negro child is high in carbohydrate to the relative exclusion of protective foods. Because of his dark skin he needs vitamin D in his diet even more than does the fair-skinned child. Lack of vitamin D in the Negro mother's diet may be one factor predisposing her infant to accelerated development of rickets.

Bad living conditions, overcrowding, and poor hygiene contribute to the production of rickets in the Negro child. Incidentally, the Eskimo, who spends a large part of his life without sunlight, protects himself from rickets by a diet high in fish oils. There is little evidence that rickets is influenced by race, save as race limits the individual's environment.

On the other side of the ledger there are several diseases for which the Negro has a greater immunity than the white man.

According to Dublin, whose figures are for Metropolitan Life Insurance Co. policyholders, there is undoubtedly less prevalence of diphtheria, scarlet fever, and German measles (and probably of measles) among Negro children than among white children, although once attacked by measles or diphtheria the Negro child shows less resistance than the white. Death from cancer of the skin is less common among Negroes. Diabetes occurs less frequently, though this difference in incidence in the white and Negro races is becoming less marked as more Negroes change from a rural to an urban environment. Infantile paralysis is less common among Negroes (*2*).

Congenital anomalies occur less frequently in Negro infants, but this may be due less to racial characteristics than to maternal age (*11*). The incidence of congenital anomalies for both white and Negro races increases with the age of the mother, and Negroes begin having babies sooner than white women and have a larger percentage of their children at an earlier age.

One very interesting racial difference is found in connection with syphilis of the central nervous system. Though syphilis is common among Negroes, both paresis and tabes are exceedingly rare (*5*), as they are also among Orientals.

To sum up, the racial differences in susceptibility to diseases that are known to exist are few, and not all to the disadvantage of the Negro. Tremendous differences in the health of the Negro and white races exist. Some of this difference may be truly racial, but most of it must be due to environmental factors and may be called the byproduct of race. It is not possible to separate hereditary from environmental factors until groups of white and Negro people can live in similar environments and be exposed to similar factors.

The earliest environment of the child is his intrauterine existence. The high maternal mortality among Negroes has been mentioned already, and the high stillbirth rate. Premature birth as indicated by weight is more common among Negroes, and is one among the many factors that raise the neonatal mortality rate. Negro children are smaller at birth than white children (*12*). It would be interesting to know whether size of the Negro infant at birth is related to economic status. With white children a recent study has shown that the birth weight of the infant and the length of the period it was carried are directly proportional to the family income (*13*). The Negro's handicap is apparent even at the beginning of his life, and coming into the world with a handicap, the Negro enters an environment unfavorable from every viewpoint.

In any enumeration of environmental factors that influence the health of any group of people, economic status stands first. Health, by and large, is a matter of dollars and cents. The income of the Negro, the Mexican, the Oriental in this country, even in good times, has been below the national average. For the same work the Negro is paid less than the white person. In the South, where four-fifths of the Negroes live and where incomes of the white population are low, the Negro has had barely a subsistence level. With the economic depression the Negro's income dropped even lower, and because he was already so low in the scale, it mattered even more to him. Charles Johnson has aptly called the Negro's status marginal (*14*). The Negro *is* marginal, in agriculture, in industry, even in domestic service. When we have an excess of labor the "margin" is wiped out.

In a variety of ways the low income of the Negro affects his health. It affects his health through the places in which he has to live. The inadequate Negro cabin of the South with its total lack of sanitary facilities is well known. In certain small towns and cities of the South where facilities are provided for garbage collection in white neighborhoods, no such facilities are provided for Negroes. In most large cities the section assigned to Negroes is an old section, no longer desired by white residents, down at heel, insanitary, and frequently rat ridden. In proportion to what he gets the Negro pays a higher rent than the white person. And what he gets is usually the lowest type of home from a health point of view.

Perhaps the point where low income represents the greatest health hazard is in food purchase. Rickets, common among Negroes, could be prevented by adequate diet, including supplementary protective foodstuffs. Tuberculosis must be influenced to a large degree by the extensive malnutrition among Negroes. One hears, of course, that the Negro buys unwisely, that his proportionate consumption of grain and fats is too high. However, studies by the United States Department of Agriculture show no startling differences in food expenditure in relation to income between white and Negro families in the same geographic region (*15*).

Income bears directly on health by its control of the purchase of medical care. Medical care has a price, and good care has, as a rule, a high price. The Negro, like others who cannot afford good care, gets his medical care from the quack or over the drugstore counter. Even if he is able to pay, the facilities open to him are few. Many white members of the medical profession decline to serve Negro patients. Facilities for training Negro physicians are not adequate. Many medical schools refuse them admission. Many hospitals close their doors to Negro internes. Few public-health officials, though possessing funds for training, make plans for training Negro physicians.

In the background of the health picture for children may be seen certain forces other than economic. One of these which has a direct bearing on the Negro child is relative lack of family stability. Whatever the cause, the Negro family is less closely knit, less homogeneous, less stable than the average white family. The matriarchal character of the Negro slave family has survived to a large degree. The woman is still the focal point of the family, but she is also frequently the wage earner. In the cities she works, when she can get work, often from 7 o'clock in the morning to perhaps 8 o'clock at night, outside her home. Adequate care of her children is impossible, and they suffer in consequence. Migration of Negro families from rural to urban areas has brought its disintegrating force to the Negro family and has added its burden of health hazard.

As improved health follows a rising scale of income, so also health follows improved educational advantages. Though in some places educational opportunities for Negroes may be equal to those for white children, in other communities they are not. Especially in communities where separate schools for Negro children are maintained is the standard of education for the Negro children below the national average.

The Report of the Advisory Committee on Education (*16*) states:

> In most of the States where there are separate schools for Negroes, the schools for white children are below the national average, yet Negro schools are only about half as well supported as white schools. . . . All the statistics for length of school term, average attendance, educational qualifications of teachers, type of school buildings, and other factors indicate that a wasteful neglect is characteristic of the treatment of Negro school children in most of the areas where they are required to attend separate schools.

Illiteracy and superstition are still common. In a well-baby clinic in St. Louis many a Negro baby has a black velvet teething collar, costing 50 cents. That 50 cents spent on cod-liver oil would be much more effective in getting the teeth through. Many of the mothers just up from the South rely on less expensive charms made of white potatoes on a string, or pennies, or nuts. Not only do poor educational facilities leave great numbers in ignorance, but opportunities for special training for Negroes are so few that only the most ambitious achieve professional standing.

That communities fail to provide public-health facilities for Negro citizens is one of the major causes of difference in racial health records. Hospital facilities for Negroes are inferior, and in some communities nonexistent. Clinics are fewer and are less well-equipped and well-manned. That is not true of all cities, of course, but by and large it is true, especially in rural areas or small towns. Here the Negro must rely on private Negro physicians, inadequate in number and often poorly trained. There has been frequent comment on the exploiting of the Negro patient by the Negro physician. Some of it is true. But the Negro physician is up against the same problem as the white physician, that of combining altruism with making a living. Incomes sufficient to pay for medical care, which are possessed by few Negro patients at best, are wiped out in a depression, and the physician is left with the altruism but without the income. The problem of medical care for the low-income class remains unsolved for the Negro as for the white family.

OTHER MINORITY GROUPS

Of the health of other minority groups in the United States very little is known. About the Mexicans, who constitute the next largest group, few statistics are available. Certain States, California for one, have made some investigations and issued some reports. The Mexican, like the Negro, lives in a community made up of his own kind. In a large city the "Little Mexico" is an old area, representing a zone of transition, is disorganized, and usually is high in crime and delinquency. In the smaller community the Mexican lives in "camp" on the edge of town, these camps being of the most temporary structure and poorest sanitation possible. Because of the migratory nature of the Mexican's work—he is usually a railroad laborer or seasonal agricultural worker (*17*)—these camps seldom attain any permanency in construction or population. A Mexican woman described the hut to which her family was assigned by the railroad as one room and a small kitchen, in which 10 people lived. "All of us could not lie down at once," she said. "We slept in turns." Because of the disadvantages from which it suffers, Mexican family life is relatively unstable. The income of the Mexican family is low and the birth rate high. The infant mortality rate is high, in California being more than double the rate for the white population (*18*). The chief causes of death among the children under 1 year are communicable diseases, gastrointestinal diseases such as dysentery, and respiratory diseases, especially pneumonia. All these diseases, of course, are those influenced by poor living conditions. In the Mexican population as a whole tuberculosis is prevalent and the death rate high. The amount of syphilis among the Mexicans is not known. The health of Mexican laborers and their families is beginning to concern health authorities. Prenatal and child-health conferences have been organized in a number of counties with a large Mexican population. That Mexicans will accept health instruction is seen by the large numbers attending these clinics.

About the health of the American Indian little more is known than about the Mexican and much less than about the Negro. Statistics are unreliable because of poor reporting, and because of the frequency with which birth and death take place without the services of a physician. The mode of life on Indian reservations and the distance of these reservations from medical centers have discouraged research and investigation of Indian problems. Living conditions among the Indians on some reservations are extremely bad. Though one is accustomed to think of the Indian as a creature of the open spaces, his living conditions at night often resemble those of the worst city tenement.

Dr. Townsend, Director of Health, Office of Indian Affairs, estimates the life expectancy at birth for Indians at about 32 years. The maternal death rate is high, but complete figures are not obtainable because many women have no physician in attendance. Many of the deliveries are by ill-trained midwives. Childbirth is not simple and safe among primitive people (*19*). The infant death rate is at least double the rate for white infants, and on some reservations goes as high as 200 per 1,000 live births.

Tuberculosis, as with the Negro and Mexican, is the great killer. The Government now has 14 sanatoriums with 1,400 beds and 81 general hospitals which take care of 1,700 patients with tuberculosis. Trachoma is another great concern of the Office of Indian Affairs (*20*). In a few sections of the country there are groups of Indians who are entirely free from trachoma; in other sections the incidence is as high as 40 percent and perhaps even higher. In the early Government schools trachoma was spread by the mixture of children from noninfected and infected groups. With the isolation of infected children in special schools and with improved methods of treatment, the amount of trachoma is decreasing. Reports from Government hospitals of the treatment of this disease with sulfanilamide are most encouraging (*21*). The Indian, contrary to popular belief, is accepting modern medical care, and his health thereby is improving.

The Outlook

Too gloomy a picture of the health situation of minority peoples in this country should not be painted. That opportunities for healthful living are unequal everyone should realize. To know that improvement is being made and how it is being made is of equal importance. The general mortality rate is going down in this country. The maternal rate and the infant rate are dropping more rapidly. That the maternal death rate for 1 year could be as much as 14 percent lower than that for the previous year is a very encouraging fact. But it is discouraging to learn that, though the death rate for Negro mothers is going down, it is not going down with as much speed as the rate for white mothers. High rates should be easier to reduce than low rates.

The health factors affecting minority groups are baffling to the forces of social planning not because of their peculiarity—American genius is sufficiently developed to deal with each of the health factors discussed in this paper. The promotional activities necessary to focus attention upon and to plan the abatement of ravaging health problems in minority groups are certainly not beyond the capacity of leadership in communities of the United States. It is through this leadership that American genius shows itself.

The improvement which is taking place in maternal and child health is the result of multiple forces that have come into play in the last 20 years. This is an era of *increasing awareness of social and economic problems.* People are interested in the welfare of their neighbors and are seeking and trying out plans for social improvement. *Education* involving the extent of health needs as well as how to meet them has taken a tremendous upswing. Reading matter for parents, motion pictures, and especially the radio are instructing a large percentage of the population day after day. *Medical science* has contributed its share in new discoveries, the most recent and most spectacular of which is the discovery of sulfanilamide and its derivatives, and their use in controlling many infections. But it is to *public-health activities* that a large share of the credit is due. (By "public" in this instance is meant not only those agencies under government auspices, but all agencies serving that portion of the population unable to pay for medical care.) Prenatal clinics and child-health clinics have been established in all parts of the country. Facilities which were once found only in large communities are going into rural areas and into small towns. The public-health nurse is a familiar sight now in many communities and is accepted as an integral part of any health program. With the enactment of the Social Security Act in 1935, States were enabled to extend and amplify their services to mothers and babies and to crippled children, including, more recently, children with cardiac defects. It is thrilling to know that all over the United States, in all our States and Territories, programs of maternal and child care are being carried out. The stories of these activities are varied in character and in scope and indicate the wide range in need and the boundless possibilities for service.

In Alaska the problem of tuberculosis among the Indians is a matter of great concern and is of increased importance in view of the defense plans for air bases in this region.

In the Southwest training of medical personnel is at present one of the main concerns. Those who are used to a large city with one or two or more good medical schools find it hard to visualize a group of five large States without one school among them. In two States there are no physicians certified as obstetricians by the American Board of Obstetrics and Gynecology. A method of training is being worked out to fit the needs of this region whereby physicians are sent to certain centers out of the State for training, and whereby a physician comes from the medical center to the State and acts as circuit rider, going from town to town and helping the local physicians with their problems in their own offices.

In the Southeast is located one of the most interesting community projects in the country, the Slossfield Health Center (*22*) in Birmingham, where an effort has been made to replace "granny" midwives with well-trained physicians. In the area served by the clinic live about 50,000 Negroes. The staff, except for 4 white consultants, is Negro and is under the direction of a Negro pediatrician. There are clinics for tuberculosis, venereal diseases, dental care, and general medical diagnosis. The infant-health service includes not only feeding instruction and immunization but pediatric diagnosis and care for sick children. The maternity service is the most complete service in the center, offering prenatal care, home delivery or delivery in the hospital at the center if needed, and postnatal care. But the interesting thing about the center is that it offers not only service to the patients, but training facilities for physicians. The physician who holds the clinic or conducts the home delivery, is a neighborhood physician working under the direction of a trained consultant. The local physician is paid for his work and in addition receives special training. It is hoped that in time all the Negro physicians of this region will have an opportunity to receive training, and it may be that Negro physicians from other States will be sent to get instruction.

Projects such as these are a good beginning. But until a positive attitude is taken toward all health problems of minority groups in this country and until all groups are provided with equal opportunities for practicing "the art of life," the health of these minority groups will remain below the national average.

Ira de A. Reid has brought this out in a poignant passage of his book, In a Minor Key, prepared for the American Youth Commission:

> So, despite the proverb, death, too, is a respecter of persons. Its heavy hand does not fall with equal frequency on youth of all colors and origins. It takes the poor youth before the rich one, the foreign-born before the native-born, and the colored youth before the white, for the art of life can be practiced well only when external circumstances are moderately favorable.

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National Conference on Nutrition Organized

Leaders in the field of nutrition, education, public health, medicine, nursing, social work, home economics, agriculture, labor, industry, government, and community organization have been invited by Paul V. McNutt, Federal Security Administrator, to attend the National Nutrition Conference for Defense in Washington, May 26–28, 1941.

The Conference consists of several general sessions and two sessions for group discussion. Each section is expected to present to the final general session a report of its deliberation with proposals for recommendations to be made by the conference to the President.

The following sections have been organized:

1. Research and national nutrition problems:
   Dr. E. V. McCollum, chairman.
   J. Ernestine Becker, secretary.
2. Economic policy and social responsibility as related to nutrition:
   Lucy Gillett and Dr. Hazel Kyrk, chairmen.
   Dr. Hazel K. Stiebeling, secretary.
3. Public health and medical aspects of nutrition—(a) general; (b) mothers and children:
   Dr. James S. McLester and Dr. Richard Smith, chairmen.
   Dr. W. H. Sebrell and Dr. Katherine Bain, secretaries.
4. Nutrition for workers in defense industries:
   Dr. Frank G. Boudreau, chairman.
   Dr. Carroll Palmer, secretary.
5. Methods of education in nutrition:
   G. Dorothy Williams and Mrs. Mildred Weigley Wood, chairmen.
   Miriam Birdseye and Edna Amidon, secretaries.
6. Professional education in nutrition:
   Dr. Lydia J. Roberts and Dr. John H. Musser, chairmen.
   Dr. Thelma Porter and Marjorie Heseltine, secretaries.
7. Nutrition problems in distribution and processing of foods:
   Dr. Hector Lazo and Dr. L. V. Burton, chairmen.
   Dr. Frederick V. Waugh and R. S. Hollingshead, secretaries.
8. Community planning for nutrition—urban—rural:
   Dr. Howard McCloskey and Director H. C. Ramsower, chairmen.
   Marjorie Vaughn and Dr. B. W. Allin, secretaries.
9. Nutrition problems in group food service:
   Mrs. Katherine Ansley and Mrs. Alberta MacFarlane, chairmen.
   Melva Bakkie, secretary.

The introductory statement to delegates by M. L. Wilson, chairman, Nutrition Advisory Committee to the Coordinator of Health, Welfare, and Related Defense Activities, points out that some kinds of nutrition problems can be met successfully by the individual and the family, but that others must be solved through State or community action designed to achieve what families cannot manage by themselves. Since in many respects nutrition is a national problem requiring a national policy if food enough to insure health is to be provided for every citizen, the President of the United States is convening the National Nutrition Conference for Defense for the purpose of making recommendations for a Nation-wide program of action.

Health for Children in Vermont

The Montpelier Conference, February 11, 1941

By Elizabeth Morrison Wagenet

Executive Secretary, National Maternal and Child Health Council, Washington, D. C.

"Toward a hardy life" is fast becoming an American slogan under the growing urgency of the times. In Vermont the hardy life is an actuality already. But the ruggedness and individualism associated with Vermonters are not indicative of a static condition. Though the population has grown little over the years, the spirit of Vermont is one of growing and becoming, of acceptance of advances proved sound, of determination to make them a part of the soul and physique of the people.

Here, in essence, was the reason for the Statewide Conference, Health for Children in Vermont, held in Montpelier on February 11, 1941. Practically, the conference rested on the belief that any public-health program depends on the interest and support of the citizens: "Each Vermonter must know what is being done to protect and improve the health of mothers and children in our State," and the converse, "We, the administrators, must know what the people need and want from public services."

This was a 1-day conference, blessed with a bright sun and an "up to zero" temperature. Snow was on the ground, but the roads were fairly clear for driving. A holiday spirit was in the air, for it was "ladies' week" at the State capital, and wives, daughters, friends of the legislators were in town.

One-room schools, city schools, all had been working on projects and posters from which, with difficulty, 300 were selected to brighten the walls of the meeting place. The auditorium began to fill with men and women long before the opening hour. Nurses in uniform conducted conference goers to their seats. The janitors were sent for more chairs until the fire-law quota was reached. Then men and women stood!

Between 400 and 500 people came. Every county in Vermont was represented, and more than 80 towns. Fifty-seven organizations and departments of State work were represented. A fundamental interest in education, in wanting to know how to advance the good of the State, probably is characteristic of an independent farm population—and 90 percent of Vermont farms are operated by their owners. So the difficulties of travel in winter did not keep the Vermonters from carrying out the conference plan.

Was the program they came to hear worth the effort? It ranged from statements in regard to the health services provided by the Vermont State Department of Public Health to descriptions of how to raise money by entertainments and committees to get local health work under way. Among those who spoke were the chairman of the Vermont State Board of Health, the executive officer of the State Department of Public Health, members of the Maternal and Child Health Division, members of the State advisory committee, the president of the Vermont Medical Society, the professor of obstetrics at the University of Vermont, and superintendents of school districts. The Governor attended the evening session and spoke.

In the conference the national aspects of health for children in Vermont were not overlooked. Dr. Clara E. Hayes of the Children's Bureau, United States Department of Labor, discussed the subject, "Better Care for Mothers and Babies—State and Nation." From the Maternity Center Association in New York City came Hazel Corbin, general director, who spoke on the conference theme, "Mother—Child—Home—Community—State—Nation."

The National Maternal and Child Health Council,[1] an organization of 60 national organizations, had been asked by the State Advisory Committee to give consultation service and assistance in building the conference. The conference was sponsored by the advisory committee to the Maternal and Child Health Division of the Vermont State Department of Public Health, A. D. Lawton, chairman. Mrs. A. M. Gay assumed the responsibility of chairman of the steering committee for this conference.

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[1] Formerly National Council for Mothers and Babies.

Vermont has a reputation for understatement. To report that since the conference at least 11 new towns have appropriated money for health services is to understate the value of the conference. A flow of increased understanding and a solidifying of purpose will be the long-time gain. "Practical visions" was the topic of the evening session. Vermont children, their mothers and fathers, the communities they live in, and even the Nation should feel the benefit of this meeting either through direct contact with Vermont services for health, or through the ripples which carry in widening circles, enthusiasms, examples, convictions.

What Vermont Has Done[2]

By Clara E. Hayes, M. D.

Maternal and Child Health Division, U. S. Children's Bureau

Each year since the enactment of social-security legislation, Vermont has made a considerable increase in its expenditures for maternal and child-health work. Also the percentage of total expenditures drawn from State and local funds has increased each year, from 32 per cent in 1937 to 44 percent in 1940.

Under Vermont's first maternal and child-health plan submitted under the Social Security Act in 1936, the staff consisted of the director, 8 public-health nurses, and 3 dental hygienists. The plan for 1941 includes the director, a dental adviser, 2 full-time local dentists, a nutritionist, and 27 public-health nurses. It also provides for obstetric consultation in certain areas. The amount budgeted for payment to local practicing physicians and dentists for services to mothers and children at clinics and conferences has been increased 40 percent and consultation service by practicing obstetricians and hospitalization and medical treatment for children have been added.

Some results of the efforts on behalf of mothers and children can now be pointed out. In the period 1934–39 there occurred a decline of 32 percent in the maternal mortality rate in the United States, the greatest decrease ever recorded for a similar period in this country. With this decrease in mortality it is reasonable to believe that there has been a considerable decrease in illness and disability associated with maternity, but unfortunately we have no means of measuring this. The decrease in maternal mortality was accompanied by a decline of 20 percent in the infant death rate and 11 percent in the stillbirth rate.

In the State of Vermont during this period there was a decline of 8 percent in the maternal death rate, 13 percent in the infant death rate, and 18 percent in the stillbirth rate. The maternal and infant mortality and stillbirth rates are somewhat lower in Vermont than in the United States as a whole.

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[2] Adapted from paper given at Conference on Health for Children in Vermont, Montpelier, February 11, 1941.

• CHILD WELFARE •
• SOCIAL SERVICES •
• CHILD GUIDANCE •

The Rural Child-Guidance Clinic

By John H. Waterman, M. D., *Director*, and Lorna S. Sylvester, *Psychiatric Social Worker.*
Tri-County Child Guidance Center, Harrisburg, Pa.

Facilities for meeting the many social needs of individuals and groups are generally more numerous and adequate in large urban centers than in the smaller more rural communities. There are obvious reasons for this. In a large community, personal and social difficulties become more apparent and more acute because of the tempo of living and the problems involved in the interdependence of individuals. When these problems become evident in urban communities, large groups of citizens either directly or indirectly concerned become active in setting up social agencies to meet these needs.

The variation between urban and rural communities becomes particularly apparent in connection with specialized agencies such as child-guidance clinics. In some 30 years of child psychiatry in the United States interest has centered largely around child-guidance clinics located in great urban communities. Excellent progress has been made. However, the gain has not been proportionately so great for the country child as for the city child. Yet the need for psychiatric services for children in other than selected city areas is being recognized more and more clearly, as Witmer points out:

> We must study the changes that have taken place in the theory and practice of favorably situated clinics and consider their implications for work outside the protected area of urban child guidance. For the challenge of the present moment is that of discovering some means by which the kind of help that is available to the few patients of the best clinics can be offered to children throughout the country.[1]

Psychological, diagnostic, and treatment services frequently are regarded by persons who are not socially interested and informed as less important than services providing maintenance and institutional care for children who present social problems. The neighborly responsibility that formerly characterized rural areas has decreased, but the transition to the acceptance of the professional, organized agency has not yet been completed. Individuals have not yet developed much willingness to give financial support to such organizations. The fact, too, that population is scattered makes the focusing of need in rural areas and, therefore, the focusing of financial support more difficult. Because the distance between families makes varied contacts impossible, individuals are aware only of isolated instances of need and, therefore, do not see the necessity for a planned program.

The scattered distribution of families also raises the question of location of facilities. It is impossible to place offices so that they will be easily accessible to all those in the area to be served.

Various methods of giving service within the limits of the community's desire for and ability to support it have been used. The traveling clinic sponsored or operated by State hospitals, universities, or private organizations has been one method. One difficulty in this method is due to the infrequency of the visits of the traveling clinic and the large number of children who must be seen in a few hours. The services rendered, therefore, may be limited primarily to tional growth is to take place. It is not always logical examination, and one or two psychiatric interviews with the child and parents. The value of such service depends largely upon the case-work skill of the social worker who is to use the diagnosis as a basis for follow-up treatment.

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[1] Witmer, Helen Leland; Psychiatric Clinics for Children, p. x. Commonwealth Fund, New York, 1940.

With the recognition of these lacks, the Tri-County Child Guidance Center was established in Harrisburg in 1938. The approach to the problem of psychiatric care for children in rural areas differed in at least two important respects from the usual approach. The center was not to be a traveling clinic. Service was to be given to the three counties of Dauphin, Cumberland, and Perry at the office in Harrisburg, the business and geographic center of the area. From the beginning it was believed that utilizing the individual parent's recognition of his child's need for psychiatric service was more important than centering attention entirely upon interpretation to the community and would lead to greater use of the center. In this way knowledge and understanding of the value of the center's services would be built up slowly, individual by individual, but personal experience seemed to be the soundest basis for interpretation. The group using the center would become a nucleus for the development of awareness of need and understanding of child-guidance services in the rural area.

Any agency with such an interpretive and slowly developing program must have the kind of support which will be continuous and secure during the period of establishment. In order to accomplish this a second relatively new but sound concept was introduced. This was that treatment for individual children could reasonably be included in the general child-welfare program. Therefore, the center was established as a division of the rural child-welfare services of Pennsylvania, under title V, part 3, of the Social Security Act, which provides for services in rural areas "for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent."

As far as general plan and physical set-up are concerned, the center does not differ a great deal from other child-guidance clinics recognized as such by the Division on Community Clinics of the National Committee for Mental Hygiene. It is a full-time clinic devoted exclusively to the problems of childhood and combines the professional services of psychiatrist, psychiatric social worker, and psychologist. Complete diagnostic, psychological, and treatment services are provided. It is housed in separate quarters in a residential section of the city but still is easily accessible to the business center and to all routes leading to Harrisburg. It has a citizens' advisory committee or board composed of lay and professional persons chosen from the areas it serves and also a professional advisory committee composed of experts in the field of child guidance. The community participates in the financial support of the center through the welfare federation, the community chest organization of Dauphin County.

The major part of the center's budget is met from Federal funds appropriated under the Social Security Act and administered by the State. This gives security to the program and makes available services which rural areas either could not or would not support financially before they had had actual experience with them. The increased complexity of administration which this entails has not proved a serious handicap during the 3 years of the center's existence. Supervisory functions are exercised by the United States Children's Bureau and the Pennsylvania State Department of Welfare, within which are the Rural Child-Welfare Services, the Bureau of Mental Health, the Bureau of Community Work, the Comptroller, and the Secretary of Welfare. It is true that on occasion there has been a delay in carrying out an accepted plan or in obtaining qualified personnel, but in general, the center has actually profited by the introjection of ideas and interests of the various supervisory departments.

The center shares the accepted philisophy of most guild-guidance clinics, which is based on the recognition of a child's need for support from his environment and of the parent's responsibility for giving this support during the process of obtaining help for the child. It also recognizes the necessity for mutual understanding between child and parent if normal emotional growth is to take place. It is not always the parent who brings the child to the center. There is one small group in which an agency is entirely responsible for the child. The foster parent or the case worker from the agency responsible for the child arranges for service and comes to the center for interviews or conferences at the same time that the child is being seen by the psychiatrist or psychologist.

The group in which the parent, or relative in parental role, makes application at the center for service, however, includes the majority of applications to the center. During the application interview with the social worker the parent decides whether he is willing to participate in this process and to what degree. This influences to some extent the kind of service which he requests for his child, although many other factors must also be taken into consideration.

The three types of service, that is, psychological study, diagnostic study, and treatment, differ from one another largely in terms of purpose and extent of service.

The psychological study of the child may consist of one to four periods with the psychologist. During these hours tests are administered to determine the child's innate ability or his particularized abilities, or his general social adjustment. Any or all of these tests may be given depending upon the particular problem of the child and upon the need for service as seen by the parent. The results of these tests and the way in which this additional knowledge may be used by the parent are discussed in interviews between parent and social worker.

The diagnostic study is similar except that in addition to the psychological tests the child has two or three interviews with the psychiatrist. Both these services are for diagnostic purposes as they afford information concerning a child's abilities, his social adjustment, his personality development, and the kind of support and help that the child needs from his environment.

The third type of service, treatment, is the one which particularly distinguishes the service of the Tri-County Child Guidance Center from other forms of psychiatric service available in rural areas. Treatment is the process of giving direct help to child and parent through regular weekly interviews at the center, child with psychiatrist and parent with social worker, for several months. During this period the child has, within the limits of the interview with the psychiatrist, an experience in living and learns with the help of the psychiatrist how to change some of his attitudes, how to relate his emotions to other people more satisfactorily, and how to become a little person who is able to live comfortably with others and yet maintain his own individuality. The parent in his or her interviews may find that there are adjustments which he must make if his child is to have an opportunity to grow up satisfactorily. He must learn how to give the child support in this developing process and how to maintain his part in the complex and meaningful parent-child relationship.

For the parent this is a great undertaking, because frequently he prefers to believe that his child should change while he himself remains unchanged or assumes no responsibility. If a parent is to be able to decide whether he wishes to participate in the treatment process it is necessary for a clinic to provide tangible points in relation to which the parent can become aware of his responsibility and indicate his willingness to assume it. At the Tri-County Child Guidance Center, the fact that parents must frequently come long distances to reach the center creates a realistic factor. In addition to the payment of fees, also used by other clinics as a focus for the acceptance of responsibility, there is the difficulty of arranging for transportation. In locating the center permanently in Harrisburg, those responsible were acting on the conviction that because most people prefer to help themselves and will make sacrifices to obtain good services, they would make use of the therapeutic tool created by distance.

Experience seems to be proving that the publicly supported, nontraveling child-guidance center serving rural areas is a sound plan. More than 75 percent of the children seen at the center have come from rural areas at their own expense. Recently a nearby community has provided a fund for transportation of those patients unable to afford their own transportation. In all, 776 children have received service at the center. They have come from 15 counties and have been referred from 46 kinds of sources. Among them, in the order of their frequency, were schools, social agencies, institutions and hospitals, and parents whose children had received service at the center previously. The increase in the number of cases has been rapid but sound. The soundness is shown by the ever-increasing number of referrals from parents and individuals.

Another interesting trend, and one which seems to bear out that a need for complete psychiatric services for children exists in rural areas, is the increasing proportion of cases in which psychiatric treatment is sought. Although at first two-thirds of the applications were requests for psychological service, applications for psychiatric treatment are now greater in number than for any other given service. Excluding cases in which consultation is requested, about 19 applications per month are made for direct service to children. Of these, 47 percent are requests for psychiatric treatment; 42 percent, for psychological service; and the remaining 11 percent, for diagnostic study.

Whereas none of the changes and trends noted may be regarded as final conclusions, they do seem to point out that there are practical aspects of the need for children's psychiatric services in rural areas which can be met by a permanently located child-guidance clinic.

BOOK NOTES

General Child Welfare

State publications Among publications recently received from State departments and organizations may be noted the following:

Biennial Report of the Bureau of Negro Welfare and Statistics, State of West Virginia, 1939–40. Charleston, W. Va., 1940. 140 pp. This, the fourth biennial report of the Bureau of Negro Welfare and Statistics, compiles facts and statistics regarding the Negro in West Virginia. The last 48 pages contain the proceedings of the West Virginia State Conference on the Welfare of the Negro, held in May 1940. The conference was divided into sections to consider health, education, vocations and occupations, employment, State institutions, race relations, child welfare, housing, and legislation. Each committee presented recommendations for solving some of the basic problems which were considered.

Aid to Dependent Children in Their Own Homes. Part 1 of this bulletin, issued by the Division for Children, State Department of Social Security, for the State of Washington (Olympia, Wash.), issued November 1940, describes the Program for Aid to Dependent Children in Washington; part 2 tells how the program operates.

Special Services for Connecticut's Crippled Persons; a directory, 1941. Connecticut Society for Crippled Children, 65 Wethersfield Avenue, Hartford, Conn. 17 pp. This directory is divided into three sections: Local facilities for orthopedic care and education, State-wide public and private services, and glossary of terms.

Public Affairs Pamphlets Recent additions to the series of 10-cent pamphlets issued by the Public Affairs Committee, 30 Rockefeller Plaza, New York, are the following:

America's Children, by Maxwell S. Stewart (1940, 31 pp.), a summary of the reports on the White House Conference on Children in a Democracy, January 1940.

America and the Refugees, prepared by Louis Adamic (1940, 32 pp.), which discusses the possibility of extending or limiting the immigration quotas and the difficulties of employment and assimilation as they affect both the country and the refugees.

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Child Welfare Services Under the Social Security Act. Child Welfare League of America, 130 East Twenty-second Street, New York, April 1940. 40 pp. 45 cents.

This is a report of local child-welfare services in the State of Oregon prior to December 1939 and has been published by the Child Welfare League of America for the convenience of member agencies and organizations interested in programs for children. The report is intended to cover content of local services to children rather than methods of administration and organization.

The Skills of the Beginning Case Worker, as Evaluated by the School, the Agency, and the Worker. Family Welfare Association of America, 122 East Twenty-second Street, New York. 30 pp. 30 cents.

The three papers contained in this pamphlet were delivered at the meeting of the case-work division of the National Conference of Social Work, May 28, 1940, at Grand Rapids, Mich.

SEX EDUCATION; FACTS AND ATTITUDES. Child Study Association of America, 221 West Fifty-seventh Street, New York, 1940. 64 pp. 35 cents.

These eight brief articles have been chosen by the Child Study Association to answer parents' questions about sex and sex education. They are intended to offer suggestions and guidance to the mature parent in search of his own philosophy. Except for the article, Concerning Masturbation, which was prepared especially for this publication, the papers are reprinted from *Child Study* and other magazines. A list of books on sex education is included.

A CITIZEN'S GUIDE TO PUBLIC HOUSING, by Catherine Bauer. Vassar College, Poughkeepsie, New York, 1940. 90 pp. 60 cents.

The author, Rosenberg lecturer at the University of California, was formerly Director of Research for the United States Housing Authority. She discusses the background of the housing question and the status of present housing programs, and offers answers to questions frequently met regarding the purpose, value, and practicability of public housing programs.

REPORT OF THE COMMISSIONER FOR THE UNITED STATES GOLDEN GATE INTERNATIONAL EXPOSITION COMMISSION, 1939–1940. Office of the Commissioner, San Francisco, Calif., 1941. 66 pp. plus photographs and tables. Processed.

This is a report, submitted by George Creel, United States Commissioner to the United States Golden Gate International Exposition Commission, on the participation of the Federal Government in the exposition. One-half of the report describes the services and exhibits of the agencies, including Children's Bureau activities in the fields of child health and child labor; one-fourth consists of photographs of the buildings and exhibits; and one-fourth, of financial statements.

Recreation and Community Organization

References on recreation

In a pamphlet entitled "RECREATIONAL RESEARCH" (1940; 63 pp.) G. M. Gloss has brought together references to some 300 books, theses, and dissertations on the subject. The discussion is arranged so that the contribution of each item to the literature is indicated briefly. Copies may be purchased from the author (G. M. Gloss, Associate Professor, School of Health, Physical Education and Recreation, Louisiana State University, Baton Rouge, La.) at $1 each.

Recreational personnel standards

SECURING AND MAINTAINING STANDARDS IN COMMUNITY RECREATION PERSONNEL is the title of a Report of the Committee on Standards of Training, Experience, and Compensation in Community Recreation Work of the National Recreation Association (315 Fourth Avenue, New York, 1940. 15 pp. 15 cents).

The recommendations and procedures suggested in this report are related to the earlier publication of the same committee, entitled "Standards of Training, Experience, and Compensation in Community Recreation Work."

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THE ADMINISTRATION OF PUBLIC RECREATION,[1] by George Hjelte. Macmillan Co., New York, 1940. 416 pp. $3.

The author, who is superintendent of recreation, City of Los Angeles, and was formerly Superintendent of Recreation, Westchester County, New York, has had a long career in recreation. He explains that the book is intended primarily as a textbook for use in college courses for those who are preparing to be recreation workers and executives. It is designed also to serve as a reference book for administrative officials and boards on the administration of recreation under systems of local government.

The subject matter is divided into three major parts, "Administrative Organization and Relationship of Recreation," "Administration of a Recreation Department," and "Related Problems of Recreation Administration."

The growth of recreation as a new function of municipal government is traced and the nature of the function is discussed. Various types of organization for recreation under municipal control are studied and the work of boards and councils as well as that of the recreation superintendent is considered in detail.

It is suggested that the schools of the future may be one type of agency through which recreation will be administered, since the more progressive schools are already organizing activities in nearly every field of leisure-time interest. Arguments are marshalled for and against school-centered programs, and the present status of such programs is discussed.

A brief report on county and rural recreation discusses the fact that public recreation is a new movement in rural areas and prophesies that it will probably "evolve through the established agency for public education in rural districts or through county governing boards and agencies established by them" with probable State and Federal aid. The functions of county and school districts are outlined and recreation projects now in operation are described.

Mr. Hjelte has called upon his years of experience in discussing such problems as accounting and financial procedure, budget making, line and staff organization, records and reports. There are brief sections on program planning, leadership, and supervision. The emphasis of the book generally, however, is placed, as the title indicates, upon the field of administration.

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[1] Reviewed by Ella Gardner, Recreation Specialist, Extension Service, U. S. Department of Agriculture.

Meet the Gang; how the Y. M. C. A. by its family policies and gang programs serves boys forced to live in underprivileged neighborhoods. Association Press, 347 Madison Avenue, New York, 1941. 72 pp. 50 cents.

That "boys in trouble point up a neighborhood problem," is the premise on which this digest is based. The material was brought together by Charlotte Himber, a psychologist working as research assistant in the Boys' Work Department of the National Council of Young Men's Christian Associations, from questionnaires, pamphlets, records, and reports forwarded by local associations to the National Council. Included are references to the literature on underprivileged boys.

The approach outlined is primarily that of preventing delinquency through community study, organization, and activities.

A Guide to Community Coordination; for coordinating community, and neighborhood councils in cities and towns under 25,000 in population. Coordinating Councils, 145 West Twelfth Street, Los Angeles, Calif., 1941. 21 plus vii pp. 25 cents.

In response to requests Coordinating Councils has published this manual of specific data on establishing councils to coordinate efforts for community service. The emphasis is not on the organization or administration of agencies but rather on the coordination of efforts of many agencies and groups in improving community conditions and meeting community needs.

Mental Development

Intelligence: Its Nature and Nurture. Thirty-Ninth Yearbook of the National Society for the Study of Education, edited by Guy Montrose Whipple. Public School Publishing Co., Bloomington, Ill., 1940. Part 1, 471 pp., $2.25 in paper. Part 2, 409 plus xxxvii pp., $2.25 in paper.

In his preface the editor refers to the current Yearbook of the National Society for the Study of Education as the "Stoddard Yearbook" and considers it sequential to the "Terman Yearbook" published in 1928, which also discussed nature and nurture and their influence on intelligence and achievement. Part 1 of the present issue, Comparative and Critical Exposition, provides the reader with varying viewpoints as presented by a group of eminent psychologists on the subject, whereas part 2, Original Studies and Experiments, presents researches either in detail or through fairly substantial summaries.

The treatment of the subject is technical and difference of opinion is frequently evident, but high professional competence prevails throughout and criticisms of methods and results as well as interpretations are set forth without personalities or rancor.

Dr. Stoddard, who served as chairman of the Society's Yearbook Committee, explains that a "democratic method" has been followed in that almost all new material available has gone in and almost nothing has been kept out. This has meant that the yearbook has provided expositions of the issues that seem important but that no fundamental conclusions are drawn and that there is no single document which is endorsed or criticized in clear and systematic fashion.

An imposing group of about 50 persons contributed to the yearbook discussions. The wide divergence in their views may occasionally prove puzzling but will undoubtedly stimulate the reader to further study.

The individual appraisal of the yearbook by the members of the Yearbook Committee is most interesting as representing their personal views of various papers included in the report.

M. R. C

Feebleminded Children as a Massachusetts Problem, by Jennette R. Gruener, Ph. D. Massachusetts Child Council, 41 Mount Vernon Street, Boston, 1941. 63 pp.

Dr. Gruener's brief report grew out of the interest of the Massachusetts Child Council in State resources for mentally retarded children. It is a discussion of present resources and methods of providing school and community care for these children and an attempt to acquaint the general public in Massachusetts with some of the pertinent problems "incident to effective provision for the mentally deficient" and with the responsibility of the community toward these problems.

Even though the report is confined to conditions in Massachusetts its findings could be of considerable interest to other States where institutional provisions may also be inadequate with the result that long waiting lists have been built up, where the training given in public-school classes has not been coordinated with a community program after the child leaves school, where the problem of the psychotic defective and the defective delinquent is a real one, and where better coordinated community planning is greatly needed.

Some general recommendations are made which the author considers obvious steps toward the achievement of more effective State planning and increased community responsibility for mentally defective children.

A short list of suggested readings relating to the mentally defective is included.

• CHILD LABOR •
• YOUTH EMPLOYMENT •
• VOCATIONAL OPPORTUNITIES •

Hearing on Proposed Hazardous-Occupations Orders for Logging and Sawmilling and Woodworking Machine Employment

Public hearings have been announced by the Children's Bureau of the United States Department of Labor, for May 28, 1941, to consider two proposed orders under the Fair Labor Standards Act of 1938, one declaring occupations in the logging and sawmilling industries and the other declaring occupations involved in the operation of power-driven woodworking machines to be particularly hazardous for minors between 16 and 18 years of age. If adopted, the orders will have the effect of applying an 18-year minimum-age standard for employment of minors in these occupations under the act.

The proposed order that concerns logging and sawmilling declares as hazardous for minors between 16 and 18 years of age "all occupations in logging and all occupations in any sawmill, lath mill, shingle mill, or cooperage-stock mill," but excepts from its provisions work in offices and repair and maintenance shops, work in the operation and maintenance of living quarters, work in timber cruising, surveying, or logging-engineering parties, work in forest protection, and work in the feeding or care of animals used in logging.

Work in timber culture or timber-stand improvement is not classed as a logging occupation and is not covered by the order, nor is work in emergency fire fighting in the event of forest fires. The order covers logging of pulpwood when pulpwood is logged in connection with the logging of timber for other uses, but it does not cover pulpwood logging where pulpwood only is logged. A later study of the hazards of pulpwood logging is planned in conjunction with a study of the hazards of pulp and paper making.

The proposed order dealing with woodworking-machine occupations declares that the occupations of operating power-driven woodworking machines are particularly hazardous for minors between 16 and 18 years of age. These occupations include feeding material into power-driven woodworking machines, helping an operator to feed material into them, or having direct control or supervision over such machines. The occupations of setting up, adjusting, repairing, oiling, and cleaning such machines are also classed as particularly hazardous as are the occupations of off-bearing from circular saws and from guillotine-action veneer clippers where such off-bearing is done directly from a saw table or from the point of operation.

The term "power-driven woodworking machines" is defined to mean "all fixed or portable machines or tools driven by power and intended for cutting, shaping, forming, surfacing, nailing, stapling, wire stitching, fastening or otherwise assembling, pressing, or printing wood or veneer."

The proposed order covers woodworking-machine occupations in all establishments subject to the child-labor provisions of the Fair Labor Standards Act.

Although the order covers off-bearing from circular saws and guillotine-action veneer clippers when such off-bearing is done directly from a saw table or from the point of operation, it is not intended to cover workers engaged in removing material or refuse from these machines where such material or refuse has been conveyed away from the saw table or point of operation by some mechanical means or by a gravity chute, nor is it intended to apply to workers engaged in moving materials from one machine to another or one part of a plant to another by hand or by truck, nor to workers engaged solely in piling or stacking materials, nor to workers sorting, tying, or loading materials.

The proposed findings and orders are based on careful investigations by the Children's Bureau of the industries and occupations and on extensive consultation with safety experts and representatives of employer and labor groups. The findings of the investigations are presented in two reports, The Hazards of Logging and Sawmilling Employments for Young Workers and The Hazards of Woodworking-Machine Employments for Young Workers, which are available upon request from the Children's Bureau, United States Department of Labor, Washington, D. C.

If the proposed orders are adopted, employers should keep on file certificates of age for all 18- and 19-year-old minors employed in all hazardous occupations, as well as certificates for all 16- and 17-year-old minors employed in occupations not declared hazardous. Through cooperative plans developed by the Children's Bureau with State offices administering child-labor laws, State employment or age certificates are accepted as certificates of age under the Fair Labor Standards Act. The act provides that if an employer keeps on file a certificate of age, issued in accordance with regulations of the Chief of the Bureau, showing that a minor employee is above the minimum age established for the occupation in which he is to be engaged, the employer is protected from unintentional violation of the minimum-age provisions of the act.

As the proposed order is to be issued under the Federal Fair Labor Standards Act, it will apply only to employers who are engaged in the production of goods that are shipped or delivered for shipment in interstate commerce. In the case of employers not covered by the act the minimum-age standards of the State child-labor law prevail, and even for employers who are covered by the act the State standard prevails whenever it is higher than the Federal standard.

Child Workers in the Berry and Bean Fields of Erie County, New York

During the summer of 1940 the New York State Department of Labor sent inspectors to Erie County to visit a sample group of berry and bean farms where seasonal workers were employed in order to obtain data on agricultural labor. On the 100 farms visited a total of 3,670 workers were employed.

This study was made at the request of Buffalo social agencies, which for some time had been concerned with the problems involved in the migration of family groups from Buffalo to work on commercial farms in the harvesting of crops. Joining in the request was the State Committee on Summer Farm Problems, which has long sought to regulate child labor on commercial farms throughout New York State.

The laboring group working in the harvesting of berries and beans was composed chiefly of women and children from the city of Buffalo, who went to the farms for the picking season and lived in labor camps. Of the 3,670 workers engaged in picking berries and beans on the 100 farms 2,156 were under 18 years of age. In fact, 1,070 of them were children under 14 years of age. Table 1, presenting the age distribution of these workers, shows that 9 percent of all the workers on these farms were under 10 years of age.

Age of hired workers engaged in picking berries and beans on 100 farms in Erie County, N. Y., summer 1940

Age	Hired workers	
	Number	Percent distribution
Total	3, 670	100. 0
Under 14 years	1, 070	29. 2
Under 10 years	330	9. 0
10 and 11 years	316	8. 6
12 and 13 years	424	11. 6
14 and 15 years	559	15. 2
16 and 17 years	527	14. 4
18 years or over	1, 514	41. 2

Boys and girls were about equally represented among the workers under 18 years of age, but among those 18 or older the women of the families predominated, 934 women to 580 men.

Conditions of the summer's work for these families were trying, not only because of the long hours in the hot sun—a 10-hour day apparently was common—but also because conditions of sanitation and decency in the labor camps were far from satisfactory. Rules of the State Department of Labor governing conditions of cannery labor camps are not applicable to labor camps on farms, but the New York State Department of Labor found such bad conditions in the 88 labor camps visited that orders to correct 1,117 violations would have been issued had the rules been applicable.

The New York State Department of Labor comments with respect to the findings of this study that "it may appall citizens of a good labor-standards State like New York . . . to know that there is still as much child labor here as this spot study would indicate. Commercial agriculture, with the exception of street trades, is the last serious child-labor problem in the State . . . The Labor Department is not opposed to young people of proper age and under proper conditions 'digging in the dirt' for hire, . . . but 8-year-olds toiling in the hot sun for 10 hours a day is certainly not conserving manpower for future industry." [1]

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[1] Release for January 10 and 11, 1941. Labor Publications Editor, New York State Department of Labor.

BOOK NOTES

American Youth Commission publications

A number of recent publications prepared for the American Youth Commission and obtainable from the Commission (744 Jackson Place, Washington, D. C.) deal with closely related problems affecting the occupational and vocational adjustment of young people, especially in rural areas. Among these publications may be mentioned:

Guideposts for Rural Youth, by E. L. Kirkpatrick (American Council on Education, Washington, 1940, 167 pp., $1). This book is concerned chiefly with finding a solution to the serious problems faced by rural youth. It records what many rural counties, towns, and organizations are already doing toward solving the youth problem locally, and in its analysis of the problem it brings to light basic principles of a practical program for its solution. Among these principles are: that the most successful enterprises are begun with surveys which provide a basis for intelligent action; that the aims should expand as the program develops; that the program must be carried out by the participants, making the fullest possible use of local resources; and that the program must be cooperative, with the pooling of ideas, efforts, and experiences.

Matching Youth and Jobs; a study of occupational adjustment, by Howard M. Bell (American Council on Education, Washington, 1940, 277 pp., $2). This report is based upon the findings and activities of a joint project carried on by the American Youth Commission and the United States Employment Service (now a part of the Bureau of Employment Security of the Federal Security Agency) to determine the needs of young people seeking jobs and to find ways of meeting these needs.

The Occupational Adjustment of Youth is an earlier, briefer statement based on the same material.

Work Camps for High School Youth, by Kenneth Holland and George L. Bickel (American Council on Education, Washington, 1941, 27 pp., 25 cents), is the story of the experiences of 58 high-school boys and girls in 3 work camps in the summer of 1940. The camps were operated by a group, the Associated Junior Work Camps, made up of parents, teachers, and youth. The campers, except for a few who held scholarships, shared expenses of the camp, paying $125 apiece for the 8-week period. In addition, each camp was located where the campers could visit "problem areas" and learn at first hand about difficulties that confront youth on farms, in mining communities, and in industrial centers.

Youth-Serving Organizations; national nongovernmental associations, by M. M. Chambers (American Council on Education, Washington, 1941, second edition, 237 pp., $2.50) has been issued for the American Youth Commission because of continued requests. The first part comments on the role of private associations in American life, suggest further studies, and present some statistics relating to membership and budget. The second part is a descriptive inventory of 320 organizations, 81 of which are classified as "youth-membership" societies and 239 as "adult associations serving youth." Information is given concerning membership, purpose, activities, publications, staff, and finances.

The Community and Its Young People, by M. M. Chambers (American Council on Education, Washington, 1940, 36 pp., 15 cents), is designed for community leaders and for public-spirited parents and youth. In it are discussed the contributions that local communities can make to solving the youth problem.

• EVENTS OF CURRENT INTEREST •

Date Set for Pan American Child Congress

March 28 to April 4, 1942, is the date set for the Eighth Pan American Congress. The Congress will be held in Washington, D. C.

The Secretary of State has designated Katharine F. Lenroot, Chief of the Children's Bureau, as Chairman of the Organizing Committee for the Congress. Miss Lenroot is a member of the Council of the International American Institute for the Protection of Childhood.

Members of the Organizing Committee are:

William G. Carr, Ph. D., director of research, National Education Association, Washington, D. C.

Henry F. Helmholz, M. D., professor of pediatrics, Mayo Foundation of the University of Minnesota, Rochester, Minn.

Warren Kelchner, Ph. D., Chief, Division of International Conferences, Department of State, Washington, D. C.

The Reverend Bryan J. McEntegart, director, division of children, Catholic Charities of the Archdiocese of New York, New York, N. Y.

Thomas Parran, M. D., Surgeon General, Public Health Service, Federal Security Agency, Washington, D. C.

John W. Studebaker, LL. D., Commissioner, United States Office of Education, Federal Security Agency, Washington, D. C.

Elisabeth Shirley Enochs of the Children's Bureau has been designated Secretary to the Committee.

Recommendations as to Children Adopted by Social-Service Conference

Recommendations based on the principles of the White House Conference on Children in a Democracy were adopted at the Conference To Maintain and Extend Social Services, which was held in New York, March 29, 1941, under the auspices of the student organization of the New York School of Social Work.

The five major areas with which the recommendations deal are:

The assurance of a livelihood for families and individuals.

The preservation and restoration of health.

The assurance for all children of suitable education and favorable conditions for growth and development.

Social services for children and adults who are at a disadvantage compared with their fellows.

The guarantee of real political, economic, and social equality, unhampered by restrictions upon creed, race, or color.

The recommendation as to children is as follows:

The White House Conference on Children in a Democracy has spoken clearly for all people on what is required to provide reasonable opportunities for all children of the country if they are to grow into adequate, happy, democratic members of the community. We heartily endorse the recommendations of the White House Conference on Children in a Democracy with respect to those services that come to children directly, such as education, vocational preparation, and welfare services, as well as those benefits which come indirectly by way of their parents and the community.

Among the measures necessary to provide for the future welfare of children are the assurance of livelihood to their parents, the prevention of disease and provision of medical services, a system of Federal grants-in-aid to States and the extension of State aid to localities for schools, libraries, recreation, and social services; also the final abolition of child labor throughout the land.

We specifically recommend the following:

(*a*) The expansion of child-welfare services under the Social Security Act.

(*b*) The passage of a law inaugurating Federal grants-in-aid to education.

(*c*) The ratification of the child-labor amendment. New York State is among those that have not ratified this amendment.

CONFERENCE CALENDAR

July 6–12	International Conference of the New Education Fellowship at the University of Michigan, Ann Arbor, Mich. Health Education Meetings have been organized by the Health Section of the World Federation of Education Associations in collaboration with the New Education Fellowship. For further information: Progressive Education Association, 221 West Fifty-seventh Street, New York, N. Y.
July 6–11	National Federation of Business and Professional Women's Clubs. Sixth biennial convention, Los Angeles, Calif. Permanent headquarters: 1819 Broadway, New York.
July 8–12	Association for Childhood Education, Forty-eighth annual convention, Oakland, Calif. Permanent headquarters: 1201 Sixteenth Street, NW., Washington, D. C.
July 13–18	American Physiotherapy Association. Twentieth annual convention, Stanford University, Calif. Permanent headquarters: 737 North Michigan, Chicago, Ill.
Aug. 10–13	International College of Surgeons, Mexico City, Mexico.
Sept. 15–19	American Hospital Association, Atlantic City, N. J.
Sept. 15–21	Second Inter-American Congress of Municipalities, Santiago, Chile.
Oct. 9–11	American Academy of Pediatrics, Boston, Mass. In charge of arrangements: Dr. Clifford Grulee, 636 Church Street, Evanston, Ill.
Oct. 14–17	American Public Health Association. Seventieth annual meeting, Atlantic City, N. J. Permanent headquarters: 1790 Broadway, New York.

U. S. GOVERNMENT PRINTING OFFICE: 1941

Senator Sheppard

With the death of Senator Morris B. Sheppard of Texas on April 7, 1941, the Children's Bureau and the children of the Nation have lost a firm and devoted friend.

Senator Sheppard will always be remembered as the co-author, with the late Representative Towner of Iowa, of the Sheppard-Towner Act, often referred to as the Federal Maternity and Infancy Act, which was in effect from 1922 to 1929 and was administered by the Children's Bureau. This act was the first Nation-wide measure under which the Federal Government cooperated with the States in promoting the welfare and hygiene of mothers and infants. It provided the foundations upon which the maternal and child-health provisions of the Social Security Act of 1935 were laid, and the experience gained in administering it proved of lasting benefit in connection with the administration of the Social Security Act.

UNITED STATES DEPARTMENT OF LABOR

Frances Perkins, Secretary

CHILDREN'S BUREAU

Katharine F. Lenroot, Chief

The Child is published monthly by the Children's Bureau, United States Department of Labor. Its publication was approved by the Director, Bureau of the Budget, May 12, 1936, to meet the need for an exchange of information between the Children's Bureau and the various agencies actively engaged in furthering the interests of children. It contains articles, brief reports, news items, and reviews of new publications relating to current developments in the fields of child health, child welfare, juvenile delinquency, and the employment of minors in the United States and in other countries

Social Statistics, issued four times a year as a supplement, contains summaries of current social statistics relating to child welfare, prepared by the Bureau's Division of Statistical Research, and is sent to everyone who receives The Child.

The Child is sent free on request to a restricted list of officials and agencies actively engaged in work for or with children. Requests to be placed on the free mailing list should be addressed to the editor, The Child, Children's Bureau, United States Department of Labor, Washington, D. C.

The Child is for sale by the Superintendent of Documents, Washington, D. C., at $1 a year; foreign postage, $0.50 additional. Single copies are 10 cents each. Subscription orders should be addressed to the Superintendent of Documents, Government Printing Office, Washington, D. C.

The CHILD

Monthly Bulletin

NAVAJO
CHILDREN
OFTEN
RIDE
THEIR
HORSES
TO
SCHOOL

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

JUNE 1941

THE CHILD

MONTHLY BULLETIN

Volume 5, Number 12

June 1941

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The Children's Bureau does not necessarily endorse or assume responsibility for the statements or opinions of contributors not connected with the Bureau.

U. S. SUPERINTENDENT OF DOCUMENTS
JUL 30 1941

• CHILD WELFARE •
• SOCIAL SERVICES •
• CHILD GUIDANCE •

Attainable Goals for the Welfare of Indian Children[1]

By Katharine F. Lenroot

Chief, U. S. Children's Bureau

In its General Report, adopted in January 1940, the White House Conference on Children in a Democracy [2] used a phrase that may well be regarded as the keynote of the conference and the follow-up programs which are now being developed in many States and localities—"Our Concern, Every Child." It affirmed that it "speaks to all the people for all the children." It gave specific recognition to the problems involved in making this concern effective in behalf of children under special disadvantages—whether of race, nationality, economic circumstance, or family or individual disability. Within these classifications the conference included the children of those who constitute, racially, our oldest American stock—the children of the Indians.

Numerically the Indians of the United States—less than 400,000 in number, of whom nearly 200,000 are under 18 years of age—constitute a population only about as large as that of Seattle. Yet, as is pointed out by John Collier, Commissioner of Indian Affairs, in his annual report for 1940 [3]—a portrayal of philosophy and of progress which everyone interested in Indians should read—this small population bears an important relation to the future of democratic institutions in the Western Hemisphere. In all the Americas there are some 30,000,000 Indians. Commissioner Collier states that by 8,000 B. C. these peoples had found their way eastward to the Atlantic seaboard and southward to Patagonia and had "proved to possess the highest capacity for adaptation, and a tendency toward rapid social evolution, while at the same time they displayed marked tenacity in holding to ancient types—physical, social, and psychological." Mr. Collier points out that in spite of essentially dictatorial and repressive policies of the United States toward the Indians, enduring for more than half a century, these policies "were not effectual in destroying the local democracy of the Indians, or even in fundamentally modifying the Indian types and Indian institutions of local democracy."

The White House Conference on Children in a Democracy claimed for Indian children, as for all the children of the United States, the fundamental rights and opportunities which are essential to individual welfare and the safety of our democratic institutions. It declared that "the effort to obtain equality of opportunity for children without regard to race, color, or creed should be pursued in the places and institutions that have potentially the greatest influence upon children." In order that this standard should permeate Government provisions for child welfare, the conference recommended that—

> In the local use of Federal and State grants the same standards should be applied to minority groups as to

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[1] Paper given at the Indian Affairs Forum, National Conference of Social Work, Atlantic City, N. J., June 6, 1941.

[2] Children in a Democracy—General Report Adopted by the White House Conference on Children in a Democracy, January 19, 1940. Children's Bureau, Washington, 1940.

[3] Reprinted from the Annual Report of the Secretary of the Interior for the Fiscal Year Ending June 30, 1940, Office of Indian Affairs, pp. 354–400. Washington, 1940.

others, and this should be a specific legislative requirement, enforced by public opinion and safeguarded by the right of the individual to appeal and to obtain a fair hearing.

Equality of opportunity does not mean identity of experience. As Grace Abbott once said, "All children are treated alike only if all children are treated differently." Services for Indian children must be based upon a profound understanding of their cultural heritage and present circumstances. As the preliminary statements submitted to the White House Conference on Children in a Democracy, presented for group discussion at the conference, pointed out—

> The Indian has never competed with the white man for jobs to any significant degree. This group has been thoroughly exploited or restricted in opportunities, and it is only in recent years that Federal policy in respect to Indians has begun to take cognizance of their culture and of what the Indian wants for himself rather than what the white man thinks he wants or ought to be.

Indians in North America are often thought of as a dying race, symbolized by the painting, "The End of the Trail." This is not true. In 1930, 42 percent of the total Indian population were under 16 years of age, although of the total white population only 31 percent were under this age. It was predicted recently by Dr. Frank Lorimer, director of population studies at American University, as reported by Science Service, that "Indians in the United States are now multiplying so rapidly that by 1980 the country may actually expect to have as many Indians as when Columbus landed in 1492." Many Indian youth of today are facing life with hope and vigor—encouraged by the achievements of their elders and eager to play a worthy part in the mosaic of American civilization. This is due primarily to what the Commissioner of Indian Affairs describes as "the new Indian program of the United States as cumulatively made effective across the last 12 or more years"—a program designed to encourage and make effective the practices and procedures of democracy in tribal and local affairs.

What are the aspirations of our American Nation for all its children? In brief, they include a satisfying home life, with enough income to assure decent, comfortable housing; adequate, nourishing food; warm, presentable clothing; health protection and medical care when needed; schooling until at least the age of 16 years, and beyond that if the child's aptitudes and interests warrant it; vocational preparation and opportunity for safe, progressive work experience; religious training; recreation and leisure-time interests; congenial companionship; experience in the democratic process; appreciation of the values and privileges of democratic citizenship, and willingness to make all needful sacrifice for the preservation of these values. These constitute the goals of democracy for every child. To secure them requires full provision for national defense, strengthening the economic resources of families and communities, and extending and improving community services for children.

For the Indian child, as for the white child, home and family are of primary importance. The White House Conference on Children in a Democracy pointed out that—

> The child has food and shelter if his family has a home and provides food.
>
> He is content and happy if he is well, if he has parents and others to love and be loved by.

Measures for safeguarding the welfare of the Indian child must begin with an understanding of the characteristics of Indian families. In most tribal groups there are strong family ties, extending beyond the circle of those immediate relatives who usually constitute the family of the white child in the United States. Kinship groups among Indians, including grandparents, uncles, and aunts, offer security to the Indian child who has been deprived of the care of his father or mother, or of both parents. The child of the Omaha tribe, for example, as well as children of many other tribes, can say, "I, a child, call all men my father, who are my father's brothers, and all women my mother, whom my mother calls sisters." Likewise, the terms "brother" and "sister" include cousins of first, second, third, or even fourth degree. In other words, relatives usually form a closely knit group held together by mutual affection, loyalty, and responsibility.

The implications of this kinship system for social work in behalf of Indian children, especially in the provision of care for children whose parents are dead or are not able to provide for them, are obvious and must be given full recognition in the development of child-welfare programs. Although economic problems, the impact of white customs, and Government policies relating to the care of children in Indian boarding schools have weakened tribal family security to some extent, it is reported that family solidarity and responsibility in general have suffered far less from contact with white American civilization than have the primitive handicrafts and economic life.

The White House Conference on Children in a Democracy emphasized the basic importance to child welfare of an income "sufficient to provide the essentials of food, clothing, shelter, and health," and stated further that—

> The basic economic problem of our children is the economic problem of the Nation—to find a sound balance of wages, prices, and financing that will provide a growing purchasing power to industrial workers and farmers and profitable investment for capital.

Indians are sometimes pictured as having comfortable allotments from the Federal Government under treaty rights or through other tribal funds; in fact, such assets are extremely limited. The Commissioner of Indian Affairs states that aside from a small amount for the relief of aged and indigent Indians, no money has been appropriated since the beginning of the century for the unearned use of able-bodied Indians except an insignificant loan fund in fulfillment of treaty obligations. It is estimated that 140,000 Indians are without independent means of support and must be assisted through some form of work relief or direct relief.[4]

Indians are described in Commissioner Collier's report as losing, on an average, 2,000,000 acres of land each year between 1880 and 1930, with the result that about 100,000 Indians were without any land. The economic and social effects of this condition were far reaching, for the whole culture and the local institutions of the Indian were founded upon the possession and cooperative utilization of natural resources. Marked progress has been made in placing the Indian family on a more secure foundation. Approximately three-fourths of the Indians are in tribes that have accepted through referendum vote the Indian Reorganization Act of 1934, which institutes reforms in land policies, establishes credit and loan funds, and encourages self-government for Indian tribes. Under the land-acquisition program, more than 4,000,000 additional acres have been made available for Indian use since 1933. Yet this is only one-sixth of the estimated land needs of the Indian population. Soil conservation and irrigation projects, conservation of timber resources, agricultural-extension and Civilian Conservation Corps projects (the Indians engaged on such projects live, for the most part, in their own homes), and rehabilitation grants to Indian tribes and groups for housing and resettlement have accompanied this farsighted program of land acquisition. Thus many of the programs for the relief of unemployment and especially of agricultural distress, which have been developed for the general population during the period of the depression, have been applied to the Indian population. This has been done within a framework adapted to indigenous economic and cultural systems and with democratic participation by the Indians in the determination of local policies and the administration of local programs.

Foundations have been laid, in the past 7 or 8 years, for the application of the recommendations of the White House Conference on Children in a Democracy relating to the economic basis for family life. Much more remains to be accomplished if Indian children are not to constitute a minority group suffering under serious economic handicaps. The amount available for the fiscal year for rehabilitation grants and relief for Indians under the appropriation bill for 1942 now pending in Congress is considerably less than the amount allocated for relief in the preceding year from emergency relief appropriations.

The White House Conference on Children in a Democracy pointed out that—

> The character of a dwelling is important to every member of the family, but especially to children, who spend so much time in and near the house and are particularly susceptible to environmental influences.

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[4] Hearings before the subcommitte of the Committee on Appropriations, House of Representatives (77th Cong., 1st sess.), on the Interior Department Appropriation Bill for 1942, pt. II, Bureau of Indian Affairs, p. 474. Washington, 1941.

Further, the report describes in general terms the standards for dwellings suitable for the rearing of children. Indian housing, on the whole, falls far below these standards. Most Indians live in areas where it is difficult to obtain raw materials for home construction. They lack funds to purchase imported materials. Under the Indian rehabilitation program new or repaired homes have been provided for some 7,000 Indian families, and more than 3,000 sanitary toilets have been constructed. Experience under this very limited program has shown what may be done toward meeting the housing needs for family life in a group that was probably the most inadequately housed of any group in the United States.

Thus far we have been concerned with economic programs administered directly through the Indian Service. These programs are designed to give the Indian an opportunity for self-support—for a living adequate to meet the necessities of life for himself and his family. The gains that have been made in the past 10 years must be conserved and extended, if we are to cherish and preserve for the Indians, as for all others in our civilization, the genius and the principles of democracy.

Beyond these measures, our Indian fellow citizens are entitled to participate on an equal basis with all others in social-security programs and in community services. Efforts to develop full cooperation between those responsible for Indian welfare and Federal, State, and local agencies responsible for general programs of health, education, and social services should be continued and extended. The functions of special programs for Indians should be to utilize the general resources available to all citizens so as to serve most fully and most appropriately the needs of the Indian population, and to develop such special services as are necessary to meet problems which are peculiar to their culture and situation.

Indians are eligible, on the same terms as other citizens, for public assistance and for social-insurance benefits under the Social Security Act. However, few have qualified for old-age and survivors insurance benefits and unemployment compensation, because for the most part they are not engaged in industrial pursuits. Surplus commodities are available to Indians, and individual Indians have been employed by the Work Projects Administration.

As of October 1, 1939, 1,817 families of Indians and 4,125 Indian children were receiving aid to dependent children. In some States the proportion of Indian children receiving aid to dependent children is somewhat lower than the proportion of white children. The average monthly grant per child as of the date cited was $7.69 for Indians and $14.91 for all children. By States, the average for Indian children ranged from $4.78 in Oklahoma to $12.83 in California.[5] The special problems involved in the administration of public-assistance programs among Indians have been well described in a recent article in *Public Welfare News*.[6]

The General Report adopted by the White House Conference asserted that "the health of the majority of persons is purchasable," and added—

> * * * many families are able from their own resources to provide the necessary care for their children. But a larger number cannot afford to do so; the population in many areas cannot support doctor and nurse; communities of limited size and means cannot afford hospitals, clinics, and competent personnel for health administration. The remedy is, in the main, to direct a suitable portion of the Nation's resources to areas where unmet needs are great.

Few accurate statistics concerning maternal and infant mortality among Indians are available, but both mortality rates and the incidence of disease are known to be high. As reported by the Bureau of the Census the infant mortality rate per 1,000 live births for Indians was 128 in 1938—more than two and a half times the rate for white infants (47) and considerably higher than the rate for Negro infants (78) in the same year. Poverty, overcrowded and inadequate living quarters, and lack of adequate resources for medical care are important contributing factors. Tuberculosis is prevalent in all tribes, with the possible exception of the

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[5] Statistical Supplement to the Annual Report of the Commissioner of Indian Affairs for the Fiscal Year Ended June 30, 1940, p. 86. Washington, 1940.

[6] Wootton, Marlow V.: Case Work Among the Bannocks and Shoshones. *Public Welfare News* (published by American Public Welfare Association, Chicago), Vol. IX, No. 5 (May 1941), pp. 2–4.

Seminoles in Florida. Trachoma, diseased tonsils, and venereal disease appear to be prevalent, though considerable progress is being made in combating these diseases.

Indian children live, for the most part, in communities where resources for health supervision and medical care are extremely limited. The Division of Health of the Office of Indian Affairs maintains and has general supervision over 12 sanatoria and 86 general hospitals in the United States and Alaska. Dispensaries and out-patient offices are provided in hospitals and outlying areas. Maternal and child-health activities and services for crippled children, carried on in all States with the assistance of Federal funds under the Social Security Act, have been widely developed, especially in rural areas, and have extended the services available to Indian children as well as to white children. Education of Indian women with regard to the value of prenatal and postnatal care is resulting in increased hospitalization of maternity cases; in fact, 80 percent of the Indian mothers are now delivered in hospitals.[7] The Office of Indian Affairs has given cooperation and financial assistance in the development of general public-health and maternal and child-health programs for which the United States Public Health Service and the Children's Bureau are responsible. Special demonstrations of particular value to Indian children have been developed in some places; for example, the five-county demonstration centering in Tahlequah, Okla. In many instances, however, isolation, language difficulty, and other circumstances make it difficult to meet the health needs of Indian children on an equitable basis.

In regard to education, the White House Conference on Children in a Democracy affirmed that—

> A primary responsibility of our democracy is to establish and maintain a fair educational opportunity to which every American child is entitled. This should be a Nation-wide goal, sought through all the thousand varieties of local conditions and traditions.

The task of education with reference to the Indian child is to introduce him to a new culture without destroying the old. It is said that there are about 200 Indian languages or dialects in the United States. Among the Navajos, for example, only about 1 person in 10 speaks or understands English. The shift from boarding-school to day-school education, though by no means complete, and the increase in school attendance are encouraging evidences of progress, but many Indian children of school age, particularly of high-school age, are not in school.

The "enrichment program" for the education of Indian children in Oklahoma is one of great promise. Under this program Indian children are received in public schools on the same basis as white children, this right being guaranteed by the State Constitution. Tuition for Indian children is paid from Federal funds, one-half being allocated to an "enrichment" fund which must be used by school districts for improving educational facilities, particularly for the purchase of equipment, supplies, library books, and so forth, needed in modern education. White children as well as Indian children have benefited greatly by this "enrichment" program.

The White House Conference recommended that the development of facilities for recreation and the constructive use of leisure time should be recognized as a public responsibility on a par with responsibility for education and health.

Lack of opportunity for wholesome forms of recreation often results in Indian adolescents engaging in activities that are destructive to character. The organization of facilities for the constructive use of leisure time should be given special consideration in relation to the development of Indian children. There is a fundamental need for the Indian to identify himself with his own group. Indian children and youth are not likely to come voluntarily to clubs or other groups organized by white Americans unless there is a well-trained and understanding leader who will stimulate their desire to participate in such activities. One of the greatest needs is for carefully selected, well-trained recreational leaders whose entire time would be devoted to the organization and supervision of community activities.

The White House Conference recognized that in a democracy responsibility for the care of children centers in the family. The General Report of the Conference states—

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[7] Based on an estimated 250,000 Indians for whom birth and death certificates are reported and for whom the Bureau of Indian Affairs assumes medical responsibility.

> Social services furnish the means by which society helps to meet the special needs of children whose well-being cannot be fully assured by their families and by those community services that are intended for all children alike. The primary objective of child-welfare service is to provide for every child who has some special need whatever assistance and guidance may be required to assure his security and protection, within his own home if possible, and opportunity for his growth and development.

To accomplish these ends the conference recommended that social services to children whose home conditions or individual difficulties require special attention should be provided in every county or other appropriate area. For children who require care away from their own homes, the conference recommended that there should be available such types of family-home and institutional care as may be necessary to insure their proper care, having due regard for special handicaps and problems of adjustment. Further, the conference urged that child-caring agencies and institutions should have adequate funds for the maintenance of children and also for such other services as are required to meet their physical, emotional, educational, and religious needs, utilizing to the fullest extent community resources available for these purposes.

Until very recently the social-service program of the Office of Indian Affairs was a part of the program of the Education Division. Recognition of the need for social service grew out of the problems of children in boarding schools and during their subsequent readjustment to community life. With the shift in emphasis from boarding-school to day-school care, and the use of foster homes in some cases for orphan children or children for whom educational opportunity is not available in the communities where they live, the social-service program can now be centered chiefly on a service to the child in his own home and under the conditions of community living which he meets. It should be possible to reduce further the boarding-school population through increased services for children who are orphaned or otherwise dependent, in their own communities, and through expanded foster-home programs.

Twenty-four social workers with some training and experience are now on the staff of the Office of Indian Affairs and 3 others working under State auspices receive half of their salaries from the Indian Office. Of the 24 on the staff of the Indian Office, 20 are assigned to Indian agencies and 4 are workers not assigned to any special territory.

Seven of these workers are Indians. Leave of absence for further training (educational leave) is encouraged. Social workers are assigned for service in Alaska and in 12 States: Michigan, Wisconsin, Minnesota, Nebraska, South Dakota, Montana, Washington, Oregon, Nevada, Arizona, Oklahoma, and California. In addition, North Dakota has 3 workers employed on the cooperative basis described. The work is carried on in close cooperation with the social workers employed by State and local departments of public welfare. In Oklahoma, for example, Indians are represented on local public-welfare committees. Many reservations, however, are without social workers. An increased number of workers, further development of field supervision, and greater professional preparation adapted to the special conditions of Indian work are needed.

The program of child-welfare services in rural areas, made possible by Federal funds granted to State agencies in accordance with plans jointly developed under the Social Security Act by the State welfare agencies and the Children's Bureau, is making available services to children in their own homes which are particularly valuable as a resource for service to Indians. Approximately 500 rural counties in the United States have child-welfare workers who have had special training and experience in social work and who are employed under the social-security program. All the States and Territories are cooperating with the Children's Bureau in these services.

In 2 States special cooperation has been developed between the State child-welfare service and the Office of Indian Affairs. Thus, on 3 of the 4 reservations in North Dakota child-welfare workers are paid half from Indian Service funds and half from State child-welfare funds. In Wisconsin the Indian Service pays $3,000 per year to the State welfare department, which is the equivalent of salary and travel for 1 worker. It also pays for foster-home care for approximately 75 children who were at the Tomah Boarding School prior to the time when it was discontinued.

In Michigan a foster-home program has been developed through the services of the Michigan Children's Aid Society, a private organization. The Office of Indian Affairs arranges through contract with this organization for the foster-home care of Indian children and pays $5 a week for the care of each child. The Michigan Children's Aid Society pays all overhead expenses. The Office of Indian Affairs has the privilege of visiting the foster homes and its worker is available for consultation service.

Many times the background of the white social worker is such that he finds it difficult to understand Indian ways and Indian customs. He finds Indians responsive to some ideas and wholly unresponsive to others. He finds Indians stubborn about little things that he takes for granted. He is likely to reach the decision that they are unpredictable and possibly irresponsible. Because they do not become enthusiastic about the same things he does, he may conclude that they are lazy and without ambition. Experiences which lead to conclusions of this kind inevitably influence action, and where the impressions are unfavorable to the Indians the action is not likely to result to their advantage.

Indian parents and other relatives should be encouraged to participate in planning for the welfare of their children. There is also need to consider the value to the child and to the parent of keeping the Indian child in his own home whenever this is possible. Under the former Indian boarding-school plan the child was taken out of his home. Experience has shown that this was a most unfortunate procedure. Indian boarding schools frequently developed into homes for semi-orphans, although a search among Indians and Indian language reveals no word for orphan. This social classification seems to be characteristic of white civilization and has brought many complications and tragedies to Indian groups. Under policies now well established, an Indian child should not be enrolled in an elementary boarding school unless suitable arrangements for him to live in the home of a relative or in a foster home cannot be made. Homes of white families should not be used as foster homes for Indian children, except in rare cases, as they cannot prepare the child for life in his own group. For children of mixed blood foster-home care by white families may prove satisfactory.

The problems of the Indian and the Eskimo child in Alaska are greatly accentuated by isolation, difficulties of transportation, and division of jurisdiction among various authorities. Alaska had a population of 72,524 in 1940, of whom 21,626 were under 16 years of age. Of these children nearly 15,000, or more than two-thirds, were of native stock—Aleut, Eskimo, and Indian. The program of the Territorial Department of Public Welfare, which administers general assistance and mothers' allowances and provides care for children who are public wards, relates only to white children. The Office of Indian Affairs is responsible for the welfare of native children. It employs 1 social worker. Only $40,000 is available annually for relief to natives, although the budget of the Department of Public Welfare, which serves the white population, totaled $210,000 during the fiscal year 1940.

The entire program of services to white and native children in Alaska needs to be reviewed and strengthened through legislative and administrative changes which will provide services adapted to the special needs of the sparse and far-flung population of this Territory and available without discrimination both to white and to native children.

In summary, progress toward the goals of American childhood as they relate to children of Indian heritage must be based on realization of the importance of extending opportunities to these children, as to all American children, on an equitable basis. The objectives must be pursued with profound understanding of the values inherent in the Indian cultures and the problems involved in preparing Indian youth, first, for effective participation in their own local democracy, and then for enjoying the privileges and discharging the responsibilities of the citizenship which they hold in common with all other Americans.

When Child-Welfare Worker and Teacher Cooperate

By Mary S. King

Licking County Child-Welfare Service, Newark, Ohio

Note.—Child-welfare services were begun in Licking County, Ohio, in November 1940. One of the early requests for service came from a school teacher. The account of this case appeared in the *Newark Teacher*, organ of the Newark and Licking County Federation of Teachers, Newark, Ohio, for April 1941 under the title, "Child-Welfare Services in Relation to the Schools," and is reprinted here by permission.

M. S. L.

Schools play a definite part in any child-welfare program, contributing to the all around development of the children who attend. The degree of contribution varies with curriculum, equipment, and especially personnel. Presumably a teacher would not and should not be a teacher unless he had an interest in children as well as in education as such and in the subjects being taught. A child-welfare worker also must be a person who likes children and adults. At the same time he must be interested in community affairs, including the program of the schools.

In any community and in any school there will be children who for some reason present graver problems than the average child, generally because of some lack in the home or community. It is with such children in particular that a child-welfare program is concerned. Teachers, of necessity, give more individual attention to such children, perhaps providing lunches and clothing if the problem is economic, tutoring after school hours if the problem is one of learning ability, spending time with parents to discuss behavior difficulties. Some of these activities are a legitimate part of a teacher's contribution to community service. However, others are not rightly a teacher's responsibility and all may become so time-consuming and burdensome that the teacher's regular duties suffer.

In this connection a child-welfare worker may be of help. Child-welfare services have been set up in Licking County at the request of the community because a number of people felt there was need for a more adequate child-welfare program. The State Department of Welfare provides these services, which are supported chiefly by Federal funds under the Social Security Act, title V, part 3. Along with a study of the community's needs and as part of the development of the services needed, goes a demonstration of case-work services to children, both in and out of their own homes, who are neglected, dependent, homeless or in danger of becoming delinquent.

For a concrete example of such service let us consider Johnnie Jones. Johnnie is a cause of concern to his teacher, Miss Smith. He came to school the first day "bearing a chip on his shoulder," and it has remained. He seems to defy both older and younger children, becoming involved in fist fights from which he often emerges badly battered. At the same time he has many likable ways. He is attractive when not scowling. He seems to be of average intelligence. Miss Smith has tried to divert his attention from "scrapping" by giving him little tasks to perform and has found that he is most eager to help. She wishes she could spare the time to give him more individual attention. However, she has to be careful that he does not win the title of "teacher's pet" since this would lead to his being teased by the other children and cause more trouble.

Miss Smith decides to refer Johnnie to the child-welfare worker. She tells the worker what she knows about Johnnie and his family. The worker does not meet Johnnie immediately, although she catches a glimpse of him in the classroom. First she visits his home, explaining to Mrs. Jones that the school is concerned about Johnnie's behavior and that she may be able to help do something about it.

She is greeted with some resentment. Why is Johnnie's behavior any concern of hers? She has to proceed slowly to find out if Mrs. Jones is aware that a problem exists and how willing she is to do something about it. She proves to be quite worried not only about Johnnie but about other domestic matters. She is harassed with the care of three younger children. She and her husband continually argue about Johnnie's behavior, each blaming the other. She is glad to find someone in whom to confide her worries, someone who is disinterested and will not go gossiping among the neighbors. At first she spends her time "letting off steam." But bit by bit the worker learns the following story.

Johnnie was a nice baby, the pride and joy of both parents for the first few months. However, his brother Ralph arrived when Johnnie was barely a year old. Ralph was somewhat sickly and required much of his mother's time. Johnnie, still a baby, was puzzled. He did not like his brother. Slightly more than a year later sister Anna arrived. She became the special pet of Mr. Jones, who would spend whole evenings sitting beside her crib talking to her. Johnnie was definitely pushed into the background. One day he took away his brother's bottle and threw it on the floor. His mother spanked him and reported the matter to his father, who gave him a severe scolding. Johnnie had the center of the stage. He began to do other mean things until he was occupying as much of his parents' time as the younger children. When another baby arrived he had to fight a little harder.

When Johnnie went to school he expected to have to fight for attention there as at home. He soon had many of the first graders thoroughly scared. He began to take on older children, some of whom enjoyed baiting him to see him fight. It seemed to Mrs. Jones that she was always cleaning him up or bandaging a bruise. Her husband was no help at all. He continued to devote considerable time to Anna. Mrs. Jones resented this and was jealous of Anna. She was also jealous of Miss Smith, because Johnnie talked so much about her in such glowing terms.

All this comes out in the interviews with the worker. Mrs. Jones has been feeling the need of some consideration, too, and when she receives it her troubles seem less severe. The worker is careful to concentrate her attention on Mrs. Jones and not on the children. Gradually she is able to discuss constructive ways of handling the situation. Mr. Jones, who has been seen from time to time, is also willing to cooperate, if only his wife will stop whining so much. Both parents try showing a little more interest in Johnnie's affairs. Mrs. Jones had not dared trust him to do anything for her. She is now persuaded to give him little responsibilities by sending him to the store on errands, letting him feel important because he can do things the other children are too small to do. Instead of playing only with Anna, Mr. Jones reads stories to the three older children. Johnnie is occasionally allowed to sit up later than the others and read a story by himself.

At school Miss Smith still allows Johnnie to help her but is lessening the time she gives to him. She lets him see that friendliness to other children is as important as erasing blackboards. Because his needs for attention are being more adequately filled at home, and because he wants the continued affection of his teacher, Johnnie is able to be less belligerent. It will be difficult for him to live down his past record with the other children, but in time and with encouragement he can win a more desirable place for himself.

Not every situation can be worked out in this fashion. Sometimes a child is so completely unwanted by his parents that he can never find security and affection in his own home. For such a child placement away from home, with a family who will really want him, may well be considered. Since a child presenting behavior difficulties and still having family ties is not suitable for adoption, he will probably need to be placed in a boarding home. An institutional placement will not help him, since he will be more lost than ever in a large group of children. His placement should be supervised so that his adjustment to the new situation can be observed and his behavior interpreted to the foster parents.

It may be that one placement will not work and that another will be advisable. It may be that no substitute home can make up for the lacks in the child's own home. Possibly he will require psychiatric help. In some cities this would be available through a child-guidance center. A child in Licking County would have to be committed to the bureau of juvenile research. He might fail to respond to treatment and prove to be a child for whose problems society can as yet do nothing. But he should not be given up as hopeless until he has been given every possible opportunity to make a satisfactory adjustment to life.

The Jones situation would have been greatly aggravated by unemployment and its accompanying economic need and loss of morale. To simplify discussion a situation was selected in which financial help was not required. Unemployment that brings economic need and loss of morale always aggravates the problems of a family. In some instances it is the basic factor in the break-up of a home. It is one of the problems which a community must face most often, and is one of the most baffling.

It is the task of the child-welfare worker to determine in each situation the best procedure to follow, to make the most of available resources, and to help develop necessary programs. In this she must work closely with the schools. Teachers and welfare workers can be of mutual assistance in their respective programs.

BOOK NOTES

Recent reports by Consumer Purchases Study The United States Department of Agriculture has issued the following publications prepared by the Consumer Purchases Study of the Bureau of Home Economics in cooperation with the Work Projects Administration:

FAMILY INCOME AND EXPENDITURES; FIVE REGIONS. In part 2, Family Expenditures, Urban and Village Series (Miscellaneous Publication No. 396, Washington, 1940, 410 pp., 40 cents), all regions of the United States were combined for the data on consumption studied in relation to family income, type, occupation, and region. Consumption patterns of city and village families and of white and Negro families are compared. Part 1, concerning income, family composition, and housing, has already been published in four volumes; each volume covers a different section of the country.

FAMILY EXPENDITURES FOR MEDICAL CARE; FIVE REGIONS (Miscellaneous Publication No. 402, Washington, 1941, 241 plus viii pp., 30 cents), presents data obtained from a survey of the medical-care expenditures of a selected group of urban, village, and farm families. A special section of 73 pages of text discusses similarities and differences between one group of villages and one of the farm groups; tables in the appendix make it possible to compare these two groups and any others and to relate medical-care expenditures with family income and composition. Medical-care expenditures amounted to about 5 percent of the net income of the native white families at most economic levels in small cities and in villages. Expenditures of farm families with comparable incomes tended to be smaller. Outlays were classified in three groups; for services, for commodities, and for health and accident insurance.

FAMILY HOUSING AND FACILITIES; FIVE REGIONS (Miscellaneous Publication No. 399, Washington, 1940, 223 plus vi pp., 25 cents), considers the housing of urban, village, and farm families—number of rooms, cooking, heating, lighting, hot or cold water, and other sanitary facilities, as they differed from one income group to another. Other factors, such as degree of urbanization, region, composition of families, occupation, and tenure of family homes are discussed. A summary describing the housing of families at three economic levels concludes the report.

FAMILY EXPENDITURES FOR AUTOMOBILE AND OTHER TRANSPORTATION; FIVE REGIONS (Miscellaneous Publication No. 415, Washington, 1941, 272 plus iii pp., 30 cents) also considers a selected group of urban, village, and farm families. Expenditures for car purchase and operation accounted for more than four-fifths of the total transportation outlays of families at all income levels in the groups of communities surveyed.

FAMILY FOOD CONSUMPTION AND DIETARY LEVELS; FIVE REGIONS (Miscellaneous Publication No. 405, Washington, 1941, 393 plus vi pp., 35 cents) has just been received and will be reviewed later.

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PATHS TO MATURITY; FINDINGS OF THE NORTH CAROLINA YOUTH SURVEY, 1938–1940, by Gordon W. Lovejoy. Sponsored by Cooperative Personnel Study, University of North Carolina, 1940.

For this survey, which was an official project of both the National Youth Administration and the Work Projects Administration in North Carolina, 44,963 boys and girls contributed information about themselves.

Child Health in the District of Columbia—The Challenge of May Day, 1941

By Ella Oppenheimer, M. D.

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It is peculiarly fitting, at this time, that the subject of child health in Washington take its place on a program dedicated to child health in the Nation. For the national-defense program is bringing thousands of people into the city—not only workers for the Government but workers for the trades and industries which must expand to meet the needs of a rapidly growing population.

The exact number of newcomers is not known, but already there has been absorbed a 30-percent increase in the supply of fluid milk to the city, and another 30 percent is anticipated by December 1941, by which time it is estimated there will be 240,000 more people in Washington. Births in the city, so far during the current year, have increased 25 percent over a similar period last year. At this rate of increase, there will be some 4,000 more births here in 1941 than in 1940.

Let us consider what has been going on in Washington before these present emergencies. Since 1936 we have shared with the other States in the Union the benefits of grants-in-aid under the Social Security Act from the United States Public Health Service for general public health and the control of venereal disease, and from the United States Children's Bureau for maternal and child-health services and services for crippled children. These latter grants-in-aid, especially, have made possible the extension and improvement of services for the protection of maternal and child health and for the care of handicapped children in areas of greatest need, although contributions from the general public-health and venereal-disease fields have also played a part, as have some increases in District of Columbia appropriations for maternal and child-health, school-health, and public-health-nursing services.

The degree to which public services for mothers and children have expanded since 1936 when the Federal grants-in-aid became available and plans for the extension and improvement of services for the group in greatest need of care were developed, is evidenced by these facts: In 1936, 688 maternity patients received prenatal care at health department clinics; in 1940, the number exceeded 5,000. In 1936 some 7,500 babies and preschool children were registered for health supervision; in 1940 the number exceeded 18,000. In 1936 the only procedure carried on at the clinics in addition to regular health supervision was immunization against diphtheria. In 1937 there were initiated treatments for syphilis for expectant mothers and for children, vaccination against smallpox, Schick tests, and tuberculin tests. Vision-screening tests of preschool children were undertaken by a group of trained volunteers under the direction of the District of Columbia Society for the Prevention of Blindness. In 1938 classes in foods and nutrition, conducted by workers of the American Red Cross in cooperation with the nutritionist of the Health

Department, were added to the activities in the clinics. The total number of visits of mothers and children to clinics for these various components of health protection has increased from 55,000 plus in 1936 to 124,000 plus in 1940.

The expansion of clinic services has been accompanied by planning for care suited to the need of the mother at the time of birth as well as home and clinic follow-up of mother and baby afterward. In addition, a study of all maternal deaths, stillbirths, and infant deaths is made currently with the active cooperation of the medical societies, and the assistance of the Children's Bureau.

In the field of services for handicapped children grants from the Children's Bureau for the extension and improvement of services for crippled children and children with conditions which lead to crippling, together with District of Columbia funds used for hospitalization and other types of care for crippled children, have made possible the beginning of a city-wide, organized program for the care of handicapped children. In 1938, when this program got under way, 268 children with crippling conditions were hospitalized for 13,496 days through the use of public funds; in 1940, 367 children were given 25,164 days of hospital care.

For a complete picture of services for mothers and children in the city add to these public services, which have been so greatly expanded in recent years, the activities of voluntary hospitals in maintaining prenatal clinics and wards which through the Community Chest assists maternity patients who can pay in part for their care; the Child Welfare Society's clinic at the Children's Hospital; the out-patient and in-patient services for sick children at the Children's Hospital and some other hospitals in the city; the services of the Instructive Visiting Nurse Society; and medical and dental care, health education, and other services of various sorts given by the medical and dental professions and many other organizations and agencies.

One might well ask, "Do the results justify the efforts?" The marked saving of infant life in Washington testifies that they do. In 1936 the infant mortality rate was 70.2 per 1,000 live births; in 1938 it fell to 48, a rate which has been maintained in 1939 and 1940. The death rate from diphtheria in 1940 was the lowest in the history of the city, and the maternal death rate in 1940 was significantly lower than in many years. The superintendent of Gallinger Hospital reports a reduction of mortality among premature infants, from 33 percent in 1939 to 11 percent in 1940, as a result of improved care made possible by limited funds granted by the Children's Bureau for urgently needed additional nursing personnel and equipment.

Another national program in which we have shared generously during the past few years and to which we are deeply indebted for active assistance in many fields of service for the health of mothers and children here is that of the Work Projects Administration. Without the WPA personnel made available during the past 2 years for our 15 maternal and child-health centers and our central office for assistant clerical, attendant, and laboratory work, our clinical services would have had to be markedly decreased. Any curtailment of this assistance now means curtailment of our clinical services, unless provision is made in a regular or special appropriation for this essential personnel. The Housekeeping Aide Service developed by an interested citizens' group and the Work Projects Administration is one the community has used actively and urgently needs for the health of its mothers and children. The same holds true for surplus commodities and the school-lunch project as long as there are underfed families in our midst.

Yet in spite of all this progress and assistance there are still many inadequacies and serious and human wasteful gaps which should be corrected promptly. Facilities for dental care are grossly inadequate for maternity patients, preschool children, and adolescents in junior and senior high schools; but we are hopeful of the impetus which the newly organized National Dental Hygiene Association will give to the provision of more adequate dental care. Mental-hygiene service should be available under public auspices if we are to prevent the warped personalities, behavior problems, and delinquency of later childhood and adult life. Inadequate provision is made in the schools for care of children handicapped in hearing or vision. Nutritional deficiencies are prevalent because of poverty and inadequate nutrition education. Facilities and nursing personnel in the public and in many of the private hospitals are inadequate to care properly for premature infants. The death rate of premature infants in the District of Columbia is higher than for the country as a whole. Increased clinic facilities are needed for the Health Department's rapidly growing maternal and child-welfare clinics. Medical and public-health-nursing personnel are inadequate to provide maternity, infancy, preschool, and school-health services in clinic and field; clinics for sick children are overcrowded. Convalescent-care facilities are lacking for all children over 12 and for colored children under 12 years of age.

Again, far too few individuals in contact with children in their homes and schools are examined for communicable disease, especially for tuberculosis, before they are employed. The present opportunity offered by the District of Columbia Tuberculosis Association, although for a limited period of time, for chest X-rays of household workers represents a significant forward step in the protection of children. Likewise, tuberculin testing of young children is far too infrequently used as a means of finding cases of open tuberculosis and subsequently protecting well children from contact with infected children.

With these evidences of what can be accomplished in the saving of the lives and health of mothers and children, and of the great deal which yet remains to protect children in Washington, we face the additional responsibility presented by the rapid growth of the population in connection with the defense program. Every problem of child health in the city is intensified by this influx, and additional resources to provide for all categories of maternal and child-health protection must be found.

Camping With Crippled Children at Greentop

By Mary E. Church

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Note.—In recent years great interest has been shown in providing camping opportunities for physically handicapped children. Many of the points to be considered are the same in the selection of a camp for a physically handicapped child as for a well child,[1] but added emphasis must necessarily be placed on some requirements which are essential in relation to the child who is physically handicapped.

As in the development of any facility it is important to have a clear understanding of the primary purposes of the camp. The purpose may be to provide intensive physical therapy in a controlled environment, to provide an opportunity for improving the nutritional state of crippled children, or to offer such children a happy experience in a healthful environment. Whatever the reason, the balance of the camp program can be maintained only if the purposes of its development are recognized.

Location.—The camp should be located at a safe distance from main highways and other possible hazards. The topography of the camp site and its immediate vicinity should be such that children with crippling conditions will be able to move about the camp easily.

Buildings.—Sleeping quarters and recreation halls should be so constructed as to offer sufficient protection from the elements and prevent undue exposure. All buildings should either be of fireproof construction or have adequate fire protection. Special ramps and other facilities, such as wheel chairs, crutches, and hand rails, should be provided for children who are unable to use steps. Equipment and furnishings, such as beds, mattresses, chairs, and tables, should be suited to the special needs of the children who will be attending the camp.

Facilities for the isolation of children who develop acute infections are important, as in other camps.

Food.—If the camp is to accept diabetic children, a well-qualified dietitian should be employed to supervise the diets of these children.

Selection of children to attend the camp.—Prior to the opening of a summer camp for physically handicapped children each season, provision should be made for physical examination by qualified physicians of all children who are under consideration for enrollment to determine whether or not they are physically able to attend the camp. The physician's report should include recommendations regarding any limitations to be observed in relation to the activities of individual children.

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[1] See Safeguarding Children in Camp, by Dorothy V. Whipple, M. D., in *The Child*, April 1941.

In selecting children for the camp it is important to consider the individual child's feeling about his disabilities. Camps for physically handicapped children may meet the need of many children but may be a threat to others who cannot become a part of such a group without unhappiness and increased insecurity.

Medical supervision and special personnel.—Continuity of medical care must be maintained in camps for physically handicapped children. Not only must there be provision for physical examination prior to admission but also continued medical supervision of each diagnostic group by qualified specialists as well as by pediatricians. Camps for physically handicapped children not infrequently employ physiotherapists and occupational therapists who have had training and experience with crippled children and who, under the supervision of the camp physician or attending orthopedic surgeon, are able to provide treatment services for selected children. In any camp for children there should be a qualified nurse to give nursing supervision to those in need of such services.

Camp activities.—In any camp for physically handicapped children careful consideration must be given to adapting the program of activities to fit the physical abilities of individual crippled children.

A few of these essential features in relation to camps for physically handicapped children have been referred to in the following article, which is based on several years of experience in one State in conducting a summer camp for crippled children.

A. L. V. H.

Camp Greentop, established by the Maryland League for Crippled Children in 1937, is primarily a health camp where every effort is made to improve the child's physical condition through physiotherapy, heliotherapy, rest, and special diets. Along with the health work the objective of the entire camp program is to develop character through new experiences. In every normal girl and boy is a powerful desire to explore and discover for himself the secrets of his own world. This desire alone is invitation enough to take every one away from the limits of four walls, so to speak, to the limitless wonderland of the out-of-doors. Crippled children living in overcrowded city areas by reason of their physical limitations have seldom been privileged to build character in nature's workshop. For them out-of-door recreation is a physical, mental, and spiritual adventure, and around these three components a camp program is created, not preplanned.

Location and Facilities.

The camp was named "Greentop" by the first group of campers, because of their appreciation of the abundance of green trees on top of the mountain. It is located near Thurmont, Md., in the Catoctin Mountains, in a tract of land owned by the National Park Service. Camp Greentop accommodates 96 children, 24 counselors, and a staff including a director, 2 assistant directors, resident physician, nurse, physiotherapist, dietitian, and kitchen staff.

The camp area consists of about 35 acres and is divided into 4 units. In each unit there are 3 cabins and a latrine. Each cabin accommodates 8 campers, a senior counselor, and a junior counselor. There are 2 recreational lodges, each offering indoor play facilities for 48 campers. The administration unit, around which the other buildings form a semicircle, consists of the administration building, a central storehouse, a kitchen-staff lodge, an infirmary, a dining hall and kitchen, a staff lodge, a central shower adjacent to the swimming pool, and a craft shop. There is also a play field of several acres.

Selection of Campers.

Physically handicapped children are the only ones considered for camp. Two-thirds of the children are from Baltimore City, and one-third from rural areas of Maryland. However, the facilities are not entirely limited to Maryland children. Special cases from the District of Columbia and adjacent areas have been accepted.

This is a program for underprivileged children, but pay cases may be accepted. Families are expected to make what financial contribution they can afford to their child's maintenance at camp.

Campers are recommended or approved by an orthopedic surgeon. All orthopedists in Maryland are members of the League's Medical Advisory Committee.

In selecting children for camp emphasis is placed on the fact that not every crippled child is considered for this camp. Many such children can and should go to camps designed for the normal child, according to the long-pursued philosophy of the Maryland League for Crippled Children—that every effort should be made to develop the crippled child to take his place in the normal social scheme.

A camper must be able to walk from his cabin to the central unit, the greatest distance being about 600 feet. A camper wearing braces and using crutches can easily accomplish this when allowance is made for slowness. The campers are white children 7 to 18 years of age; 48 are boys, and 48 are girls. On the principle that these children would derive little benefit from short camp periods, it is the established policy to take campers for the entire camp period of 8 weeks.

A review of the causes of the campers' disabilities for the last 4 years shows that poliomyelitis is responsible in 32 percent of the cases. Tuberculosis of the bone, cerebral palsy, scoliosis, traumatic deformities, and congenital deformities are next in order of frequency, and there are occasional cases of crippling due to various other causes. Some children who need a minimum amount of physiotherapy, or who merely need the protection of restricted activity, are chosen because of their social needs. These needs are determined by the social-service workers on the staff of the Maryland League for Crippled Children, who know through their constant supervision of the homes the family limitations and the lack of understanding on the part of some parents.

Staff and Staff Training.

Good leadership in camping is a quality that must be found not only in the director, but in every member of the staff. Qualities of successful leadership of greatest importance are responsibility, mature judgment, and emotional maturity. Leaders and counselors are expected to be mature adults capable of managing their own lives before they start trying to handle the problems of others.

The director of Camp Greentop has been with the camp since its inception and now has a total of 25 years of camp experience to his credit. He is a teacher of physical education in a boys' high school. The assistant director for boys is vice principal of a grade school and has had 11 years of experience in camping, 4 of which have been at Camp Greentop. The assistant director for girls also is a teacher of physical education in a coeducational junior high school and now has a total of 7 years of camping experience, 4 of them at Camp Greentop.

Six women and 6 men compose the staff of senior counselors, chosen for their ability as counselors in arts and crafts, nature lore, recreation, music, and for their general experience in leadership. For the past 4 years the senior staff has consisted of 5 teachers, 2 medical students, and 5 college students. No one under 21 is considered as a senior staff member, and the average age has been about 25. There is a junior staff of 12 counselors, consisting of younger college and high-school students at least 17 years of age with special leadership ability. Each junior is assigned to a senior counselor as assistant in the field for which the senior has been chosen.

Applicants who are accepted are notified to report for a training class, which consists of four lectures covering camp organization, camp pedagogy, camp program, and medical factors to be considered.[2]

A program of in-service training is a part of the camp policy. It is carried out by means of frequent professional meetings of the entire staff, meetings of sections of the staff, and individual conferences of staff members and directors.

Program.

Confronting the staff in their work is the fact that these campers are physically handicapped children, some of whom have had extended periods of hospitalization, or come from homes where they are either overprotected or are subjected to distressing environments. Again, the crippled child is blocked in his recreational needs in his own neighborhood. This child desires not only to belong to the neighborhood gangs, but to participate in the general social life of a child. The philosophy of the camp is to allow children to develop freely under new leadership and along new lines in the camp environment.

The most valuable parts of the program are those in which there is the greatest camper participation. Ideally the campers would originate the activity, plan its execution, and carry it through to a successful conclusion with staff help kept to a minimum or dispensed with altogether.

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[2] The training course for camp leaders, including both the four lectures and the program for in-service training, is being prepared in booklet form and will be available later from the Maryland League for Crippled Children.

After rising bell at seven o'clock, breakfast at eight o'clock, cabin clean-up, and so forth, the morning hours are free for group activities. Each camper before coming to camp is graded by his own orthopedist, who designates activities for him, such as ball games, hiking, amount of swimming. This information is filed both with the counselor in the child's cabin and with the assistant director. Campers decide when to play active games, softball, deck tennis, table tennis, and so forth, with rules changed to suit their disabilities. Toward the end of camp season tournaments in nearly all activities become extremely popular. A camper committee of nine makes the rules, the schedule, and all plans, showing fine evidence of careful judgment and enthusiastic participation. The younger children enjoy games such as croquet, miniature golf, and a variety of circle and group games; and the girls make camp gardens, cut paper dolls, and play mothers. It is traditional for the little girls 8 to 10 years of age to act as hostesses at parties, and to initiate the first outdoor breakfast, planning their own menu with the counselor and dietitian, and inviting the boys of the same age group and the administrative staff.

Swimming is a favorite sport. At the beginning of the season children are allowed to go bathing, but no effort is made to teach them to swim. The swimming counselors observe and jot down notes to enable them later to place each camper in a swimming group where he will be able to learn to the maximum advantage. Here there is close supervision and cooperation from the physiotherapist who treats the majority of the cases during the school term. Specific exercises are recommended for some children, and certain swimming strokes are supervised.

The arts and crafts shop is fully equipped so that any child even with little initiative or little imagination finds ample opportunity to develop skills, appreciation of good workmanship, and motor coordination. Unlike the school workshop, there is no set curriculum, so that the child may use materials at hand or materials furnished by nature to develop his creative powers. Included in these crafts are leather work, metal tapping, woodworking, wood burning, aeroplane building, craft strip, boat building, and many other activities difficult to classify. The recreation lodge in the girls' unit offers facilities for basket weaving, knitting, sewing, making doll babies, crocheting pocketbooks, and many other activities.

Emphasis is placed on the occupational-therapy aspect of craft work for children designated by the medical staff.

The surroundings of the camp offer limitless opportunities for nature study. Wild flowers abound near the waterfall. Each summer gardens are planted around the cabins, especially in the girls' and the small boys' sections. Spatter prints offer a valuable opportunity to study the various trees and leaves. Butterflies and moths are caught and mounted as permanent nature displays. "What is this?" is a contest carried on throughout the camp season. It consists of identifying a new nature specimen displayed each day. Many books on wild flowers, birds, and trees are found in the nature library for use of the campers. Hikes offer an opportunity for the campers to discover the habitat of birds and rabbits. Nests of the ring-necked pheasants and the bobwhites are often found.

The older girls and boys express their appreciation for their camp experience by making some pioneer project their objective. As a gift from the 1940 group there is now an overnight camp site with an Adirondack lean-to, open fireplace, and frames for cots. Under the guidance of the boys' senior counselor all plans were drawn up, wood shaped, and stones placed in position by the older boys. The girls made the canvas covers for the cots.

Two camp libraries are a great joy to the campers. A camper assumes the responsibility of librarian, checking books in and out. The books are the gifts of organizations and friends, and the shelves are a contribution by the boys.

Medical Supervision.

Medical supervision starts with the Medical Advisory Committee of the Maryland League for Crippled Children composed of 16 orthopedists, 2 of whom are assigned to visit camp once a week on different days. They act as consultants to the resident doctor and nurse in problems arising from activities on the part of some campers, adjustment of braces, periods of swimming, and so forth. In camp the physiotherapist is responsible for all matters pertaining to orthopedic appliances, because of her intimate knowledge of about two-thirds of the children at camp. Out of camp season she is physiotherapist at the public school for handicapped children in Baltimore, supervised weekly by the same group of orthopedists.

The camp doctor and nurse are in charge of the infirmary, which is well equipped to care for 8 sick campers at a time (more if necessary). Such minor injuries as cuts and bruises are promptly taken care of, and regular dispensary hours are established for the return of patients needing care. A neighboring physician acts as consultant on all cases where there is any doubt as to diagnosis and treatment. An excellent hospital 14 miles away is available for any serious injury.

The nurse has charge of the weekly weighing period and, with the camp clerk (an older handicapped girl), records all treatments, weights, and so forth, in the camper's medical history.

All matters of food are handled by the dietitian, including food purchasing and menu planning. Campers who require extra nourishment report at a regular time in the morning and afternoon. The average number receiving special diets is 33.

Summary and Evaluation.

It is difficult to evaluate all benefits enjoyed by the children. Their social experience has been broadened and the wonders of nature have been opened to them in contrast to the narrow alleys and corner playgrounds of the city. The counselors keep a record of each child's progress and social responses. Campers are usually examined by their orthopedist shortly after return from camp. The reports made frequently show improvement in general physical condition, including gains in weight, and so forth. Marked improvement in muscle tone is noted in some cases as a result of increased outdoor exercise.

Campers are constantly relating camp experiences in their classrooms, where improvements in poise and social security are most noticeable. Parents report that the campers show more consideration for others in the home, more self-assurance, more unselfishness in sharing playthings, more obedience, and most of all a sense of appreciation for surroundings, a greater joy in living. The spiritual life of the child is enriched through a new concept of God in nature, through the quiet reverence around the weekly council fire, through vesper services, the singing of hymns and camp songs, and in some instances through new friendships established between campers and counselor. All these values may not be found in every child, but certainly they are found to such an extent that every effort to provide a camp experience for crippled children should be encouraged. It is another opportunity for that fullness of life barred in so many instances by physical handicaps.

BOOK NOTES

SUNSET CAMP, ANNUAL REPORT, 1941 (Sunset Camp Service League, Bartlett, Ill., 1941, 46 pp.) states that the purpose of Sunset Camp is "to give a happy and healthful vacation to Jewish school and working girls and to offer convalescent-camp care and recreation to children with heart disease." Children with heart disease are referred to the camp by social agencies and cardiac clinics. In 1940 three-fifths of the children came from families receiving relief. The camping season for children with heart disease was extended from 3 months to 5 months in 1940, and most of the children profited greatly by the longer season. The services of a consulting psychiatrist were available, and attention was focused on meeting the needs of each child as an individual.

DIRECTORY OF CAMPS AND SUMMER ACTIVITIES FOR CRIPPLED CHILDREN IN THE UNITED STATES, 1941, has been issued by the National Society for Crippled Children, Elyria, Ohio, as *Institutional Bulletin* No. 31, May 1914 (7 pp. Mimeographed). This is now issued annually and gives the address, sponsor, and capacity of camps for crippled children, with brief details as to types of children accepted and cost of care.

The Maintenance of Safeguards for Youth

Because it so clearly expresses the urgent need of maintaining the standards which have been set up for the employment of minors, a resolution which has been introduced into the Pennsylvania Legislature is of general interest.

It furnishes evidence from one of the largest industrial States that the safeguards that have been established as necessary for the health and welfare of youth should not be sacrificed in an emergency program.

The resolution reads as follows:

Whereas the education and welfare of the children of the State are fundamental to the future of Pennsylvania, and

Whereas Pennsylvania has recognized this in the past by enacting a system of compulsory education and by enacting laws for the regulation of employment of minors, and

Whereas in the World War Pennsylvania witnessed a great increase in child delinquency accompanied by a tendency to disregard the compulsory school-attendance laws and the child-labor laws, and

Whereas in the present emergency there is a danger that these conditions may arise again, a situation which all enlightened citizens desire earnestly to avoid: Therefore be it

Resolved, That the Legislature of the Commonwealth of Pennsylvania call upon all local school boards to be vigilant in the enforcement of the compulsory-attendance laws; and be it further

Resolved, That the Legislature of the Commonwealth of Pennsylvania call upon the Department of Labor and Industry by enlarging the appropriate divisions if necessary to enforce strictly the child-labor laws of this State.

* * *

Governor Olson of California has vetoed a bill passed by the California Legislature which would have permitted boys as young as 10 years of age to sell papers on the streets and would have eliminated the present requirement for work permits for newsboys.

In his veto message the Governor stated, "The people of the State of California have been proud of the success of their efforts to safeguard women and children in industry."

* * *

Governor Lehman of New York has added his voice in protest against relaxing child-labor standards by vetoing a bill passed by the General Assembly of New York State which would have lowered the present standards set for the employment of children in theatrical and other public performances.

BOOK NOTES

INDUSTRIAL HOME WORK IN THE UNITED STATES, by Frieda S. Miller. *International Labor Review*, Vol. 43, No. 1 (January 1941), pp. 1–50.

The history of industrial home work in the United States is traced from the Colonial Period to the present time. Miss Miller speaks from first-hand experience of administration of industrial home-work and minimum-wage laws, as she has been industrial commissioner of the State of New York since July 29, 1938, and previously was director of the Division of Women in Industry and Minimum Wage of the New York State Department of Labor. Early attempts at regulation, the situation under the National Recovery Administration, the effect of recent State and Federal legislation, and home-work conditions as revealed by recent studies are described.

In describing the attitude toward home work in the United States, Miss Miller says:

> The overwhelming majority of American government officials who have ever had anything to do with the administration of laws designed to regulate industrial home work are firmly convinced that it can never be satisfactorily regu-

lated. Low wages, long hours, child labor, unhealthy and insanitary working conditions—evils which long have characterized industrial home work in the United States—are part and parcel of the system, they believe, and complete abolition alone can actually eliminate them. This belief is shared by organized labor, civil and social leaders, public health authorities, consumers' groups, and the more progressive employers—all of whom look upon home work as a parasitic growth on the industrial system, injurious to the community at large and especially to factory workers, whose standards are undermined by the competition of home workers.

• *EVENTS OF CURRENT INTEREST* •

Recent Children's Bureau Publications

PROBLEMS AND PROCEDURES IN ADOPTION, by Mary Ruth Colby. Bureau Publication No. 262, Washington, 1941. 130 pp. This study discusses the administration of adoption laws in nine States where the State public-welfare department has a responsibility for investigating petitions for adoption and for leadership in the whole field of adoption. It contains factual and statistical information showing what children are being adopted, how they find their way into their adoptive homes and by whom petitions for adoption are filed. One section is devoted to the services of the State department in the development of sound adoption practices. Another discusses the place of the court in adoption procedure and the importance of certain specific legal provisions in adoption laws. In the concluding section the implications of the findings are summarized and points needing special consideration in revising State adoption practice are listed.

MATERNITY CARE AT PUBLIC EXPENSE IN SIX COUNTIES IN NEW YORK STATE. Bureau Publication No. 267, Washington, 1941. 84 pp. Data are included on all maternity patients who received medical or nursing care paid for from public funds July 1, 1935, to June 30, 1936, in the six counties studied. The report, which was written by Beatrice Hall, medical social consultant, who also supervised the study, brings to light considerations of general significance in the provision and administration of maternity care in rural areas. It also gives consideration to the problem of providing maternity care for women in families that are able to maintain themselves but unable to pay for necessary maternity care.

RECORDING CHILD-WELFARE SERVICES. Bureau Publication No. 269, Washington, 1941. 38 pp. This is the report of the Committee on Case Recording in Public Child-Welfare Agencies in Rural Areas, appointed in 1938. The principles of case recording are approached from the point of view of services needed by children rather than from the point of view of agency functions. Case recording is dealt with as an integral part of case treatment, and the discussions are therefore focused on adequate case treatment as related to the total needs of the child.

INDUSTRIAL HOME-WORK CONDITIONS IN THE CANDLEWICK-BEDSPREAD AND LACE INDUSTRIES. Prepared by the Children's Bureau and transmitted to the Wage and Hour Division of the United States Department of Labor in January 1940, this report is now available in mimeographed form (Washington, 1941, 50 pp.). The findings show that the use of children under 16 years in industrial home work continues in spite of legislation prohibiting it in both the industries studied. The report recommends that factory production be substituted for industrial home-work production as the most effective means of guaranteeing fair labor standards.

FACTS ABOUT CHILD HEALTH. 11 pp.

FACTS ABOUT CRIPPLED CHILDREN. 15 pp.

These two pamphlets have been revised as of March 1941.

Additional Summer Courses

In addition to those announced in the April issue the following courses relating to work with children and youth are being offered this summer:

Vassar College, Poughkeepsie, N. Y., has a summer workshop, June 19 to July 31, for the study of personality development. This is designed to provide advanced training in guidance for workers in education, social work, pediatrics, and school health. Further details may be obtained from Dr. Caroline B. Zachry, director, Institute for the Study of Personality Development, 221 West Fifty-seventh Street, New York.

At Mills College, Oakland, Calif., the Department of Child Development is offering a course with the general subject of child psychology as a basis for solution of today's crucial problems, June 29 to August 8. For further information write to Director of Summer Session, Mills College, Oakland, Calif.

Stanford University School of Education is holding an institute July 17–20 on Education for the National Emergency and After. Information concerning the institute may be obtained from the General Chairman, Fiftieth Anniversary Celebration, Room 173, Administration Building, Stanford University, Calif.

CONFERENCE CALENDAR

July 6–12	International Conference of the New Educational Fellowship at the University of Michigan, Ann Arbor, Mich. Health Education Meetings have been organized by the Health Section of the World Federation of Education Associations in collaboration with the New Education Fellowship.
July 6–11	National Federation of Business and Professional Women's Clubs. Sixth biennial convention, Los Angeles, Calif. Permanent headquarters: 1819 Broadway, New York.
July 8–12	Association for Childhood Education. Forty-eighth annual convention, Oakland, Calif. Permanent headquarters: 1201 Sixteenth Street NW., Washington.
July 13–18	American Physiotherapy Association. Twentieth annual convention, Stanford University, Calif. Permanent headquarters: 737 North Michigan, Chicago, Ill.
Aug. 10–13	International College of Surgeons, Mexico City, Mexico.
Sept. 15–19	American Hospital Association, Atlantic City, N. J. Permanent headquarters: 18 East Division Street, Chicago, Ill.
Sept. 15–21	Second Inter-American Congress of Municipalities, Santiago, Chile.
Sept. 29–Oct. 3	National Recreation Association. Twenty-sixth National Recreation Congress, Baltimore, Md. Information: National Recreation Association, 315 Fourth Avenue, New York.
Oct. 6–10	National Safety Council. Thirtieth National Safety Congress and Exposition, Chicago, Ill. Managing director: W. H. Cameron, 20 North Wacker Drive, Chicago.
Oct. 9–11	American Academy of Pediatrics, Boston, Mass. In charge of arrangements: Dr. Clifford Grulee, 636 Church Street, Evanston, Ill.
Oct. 14–17	American Public Health Association. Seventieth annual meeting, Atlantic City, N. J. Permanent headquarters: 1790 Broadway, New York.
Oct. 27–31	American Dental Association. Eighty-third meeting, Houston, Tex. Permanent headquarters: Chicago, Ill.

U. S. GOVERNMENT PRINTING OFFICE: 1941

*93 3.5 A7

Social Statistics

Supplement Numbers 3 and 4, March and June 1941

to

THE CHILD—Volume 5

UNITED STATES DEPARTMENT OF LABOR
FRANCES PERKINS, SECRETARY

CHILDREN'S BUREAU
KATHARINE F. LENROOT, CHIEF

SOCIAL-STATISTICS SUPPLEMENT

Numbers 3 and 4 March and June, 1941

TO

THE CHILD, MONTHLY BULLETIN, VOLUME 5

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Maternity-Home Care - 3

Day-Nursery Care in 34 Urban Areas, 1940- - - - - - - - - - - - - - - - - - 10

During the years 1937 through 1940 monthly reports were submitted to the Children's Bureau from 84 maternity homes located in 37 of the 43 urban areas included in 1940 in the social-statistics project of the Children's Bureau. 1/

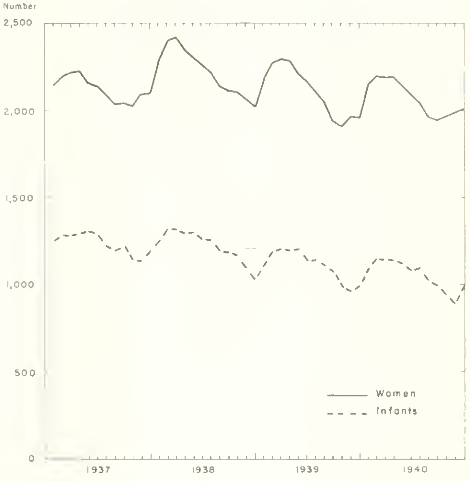
A maternity home as defined for purposes of the social-statistics project is a special institution providing continued care for unmarried mothers preceding and following the birth of their children, or a special unit for this purpose provided by hospitals or other agencies. It is the practice of some maternity homes occasionally to accept other women in need of maternity-home care.

Maternity-home care is only one part of the services provided for unmarried mothers in a well-organized plan for their needs, and it is recognized that reports on the type of care given by maternity homes form a very incomplete picture of these total services. The most important consideration in this connection is the lack of information on casework services provided to unmarried mothers by family-welfare, child-caring, and health agencies. 2/

Trend and Seasonal Variations

According to reports received from the 84 maternity homes from 1937 through 1940 there were 2,135 women and 1,242 infants under care at the beginning of the period and 2,011 women and 988 infants at the end. The figures reported indicate a slight downward trend both in the total number of women and of infants under care and rather marked seasonal fluctuations during each year of the period (chart 1).

CHART 1.— TOTAL NUMBER OF WOMEN AND INFANTS UNDER CARE OF MATERNITY HOMES ON THE LAST DAY OF EACH MONTH, 1937 TO 1940, AS REPORTED BY 84 AGENCIES IN 37 URBAN AREAS



The number of women and infants under care in individual areas on December 31 of each year is shown in table 1 (page 4). Thirty areas reported no consistent increase or decrease throughout the period in the number of women under care. Only 2

1/ The 37 areas included in this article have indicated that all service provided in the reporting areas of the type defined was reported. Of the 6 registration areas excluded New Haven, Springfield (Mass.), and Wilkes-Barre reported that no service of the type defined was provided during 1940; and reports were not received from maternity homes in Canton, Dayton, and Hartford. An article published in Social Statistics, June 1938, gave data on 39 areas for 1937. Five areas (Dayton, Hartford, New Haven, Springfield (Mass.), and Wilkes-Barre) which are not included in this article were included in the earlier article, and 3 areas have been added (Duluth, Fort Worth, and San Francisco).

2/ Studies recently conducted in several areas have revealed serious gaps in the services available and have made it apparent that there is insufficient knowledge of the extent of the problem of unmarried parenthood in the areas.

Table 1.--Number of women and infants under care in maternity homes on December 31 of 1937 to 1940 as reported by 84 agencies in 37 areas

Area	Territory included	Number of agencies	Number under care on December 31							
			Women				Infants			
			1937	1938	1939	1940	1937	1938	1939	1940
Total..............	....	84	2,107	2,019	1,961	2,011	1,192	1,032	993	988
Akron..................	County....	1	10	8	16	17	4	3	9	5
Atlanta................	Area[a].....	1	25	19	24	31	15	11	9	10
Baltimore..............	City......	1	40	26	22	22	37	32	27	17
Birmingham.............	County....	1	44	38	26	32	19	21	12	18
Boston.................	City......	5	[b]141	[b]129	120	138	[b]67	[b]58	64	75
Buffalo................	County....	4	88	91	81	82	68	44	53	40
Chicago................	County....	5	151	164	146	138	65	67	43	46
Cincinnati.............	County....	3	98	73	85	83	74	52	46	52
Cleveland..............	County....	4	130	125	121	105	83	85	73	68
Columbus...............	County....	3	41	60	53	47	24	25	21	22
Dallas.................	County....	1	23	28	[b]25	19	2	6	......	1
Denver.................	County....	2	71	74	79	65	38	42	44	37
Des Moines.............	County....	2	55	48	53	33	23	19	26	11
Detroit................	County....	4	157	140	163	153	82	63	63	65
Duluth.................	County....	2	21	20	22	28	10	13	13	11
Fort Worth.............	County....	1	15	17	18	19	3	2	3	7
Grand Rapids...........	County....	1	27	32	29	27	24	22	16	12
Houston................	County....	1	12	12	17	19	8	2	7	11
Indianapolis...........	County....	2	16	20	16	23	12	16	18	21
Kansas City, Mo........	County....	3	62	64	45	44	28	21	22	20
Los Angeles............	County....	3	99	95	82	100	52	38	41	40
Louisville.............	County....	1	27	30	26	26	19	16	13	11
Milwaukee..............	County....	2	67	65	56	46	40	33	25	30
Minneapolis............	Area[c].....	3	76	78	74	92	47	45	40	46
Newark.................	City......	1	23	13	26	29	21	16	24	20
New Orleans............	Parish....	2	36	33	41	51	25	31	34	41
Omaha..................	County....	2	45	41	38	46	27	16	21	9
Pittsburgh.............	County....	6	95	83	80	79	69	37	40	43
Providence.............	City......	1	12	13	19	12	9	9	6	6
Richmond...............	Area[d].....	2	27	22	34	33	16	13	27	29
St. Louis..............	Area[e].....	3	64	44	51	64	33	23	22	28
St. Paul...............	County....	2	69	78	61	75	38	34	32	35
San Francisco..........	County ...	3	83	92	83	83	34	39	31	25
Sioux City.............	County....	2	37	36	[b]29	38	14	15	[b]10	17
Syracuse...............	Area[f].....	1	22	16	15	10	17	14	10	9
Washington, D.C........	City......	2	68	68	56	69	33	38	34	38
Wichita................	County....	1	30	24	29	33	12	11	14	12

[a] Includes DeKalb and Fulton Counties.
[b] Includes estimates.
[c] Includes city of Minneapolis and village of Edina.
[d] Includes Independent City of Richmond and Chesterfield and Henrico Counties.
[e] Includes city of St. Louis and St. Louis County.
[f] Includes city of Syracuse, and villages of East Syracuse and Solvay.

areas (Fort Worth and Houston) reported consistent increases, and 5 areas (Baltimore, Cleveland, Milwaukee, Pittsburgh, and Syracuse) reported consistent decreases. In the number of infants under care 30 areas reported no consistent change, 2 areas (Indianapolis and New Orleans) reported an increase each year, and 5 areas (Baltimore, Grand Rapids, Louisville, Providence, and Syracuse) reported a decrease each year.

The number of women under care on any given date is usually considerably greater than the number of infants, primarily because of the number of women under care who have not yet given birth to their children. Although over a period of time this difference is less marked, the number of women admitted to care will be found still to exceed the number of infants. Other factors influencing this difference include: The practice in some homes of caring for the infants in a separate home located in a different part of the institution; the occasional case in which a woman may leave the home before her child is born; and cases that result in miscarriage or stillbirth.

On the other hand, an important factor that may result in a large percentage of infanta under care (even to the extent that in a few instances there were actually more infants than women) is that some institutions are in reality a combination of maternity home and child-caring agency and keep the infants in the home after the mothers leave. Also of some importance in this connection is the practice in some maternity homes of occasionally admitting foundlings and other newborn infants in need of special care but born to women not under care.

Extent of Maternity-Home Care During 1940

The total number of women cared for in these homes at some time during 1940 was 9,942. The number ranged from 62 in Akron to 981 in Chicago. Separate figures for the 37 areas are presented in table 2, page 6.

The number of women cared for in an area is influenced by the policy of the individual institution with regard to duration of care and the extent to which facilities for this type of care have been developed. The number of women cared for per 100,000 total population as shown in table 2 varies from 8 in Baltimore to 193 in Syracuse. The median rate is 40, and the middle 50 percent of the rates lie between 25 and 67. When the rate is computed for resident women of each area, Baltimore and Syracuse are again at the extremes. It

CHART 2.—PERCENTAGE OF WOMEN UNDER CARE OF MATERNITY HOMES WHO WERE RESIDENTS OF THE AREA, AS REPORTED BY 84 AGENCIES IN 37 URBAN AREAS, 1940

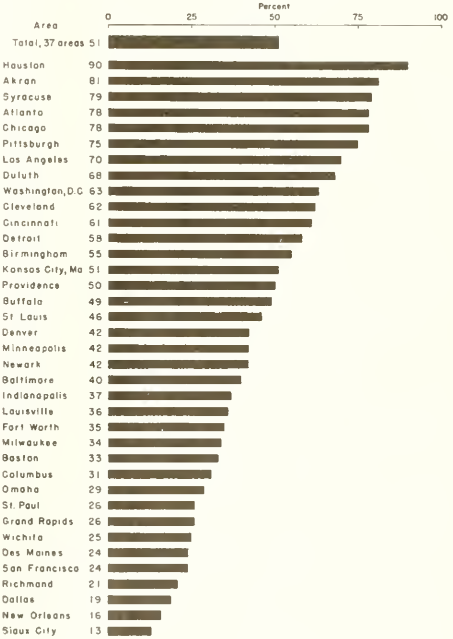


Table 2.—Number of women under care of maternity homes and percentage who resided in the area, as reported by 84 agencies in 37 urban areas, 1940

Area	Number of agencies	Number of women under care			
		Total	Per 100,000 population	Residing in reporting area	
				Number	Percent
Total	84	9,942	39	5,106	51
Akron	1	62	18	50	81
Atlanta	1	79	16	62	78
Baltimore	1	73	8	29	40
Birmingham	1	126	27	69	55
Boston	5	604	78	201	33
Buffalo	4	510	64	252	49
Chicago	5	981	24	763	78
Cincinnati	3	328	53	200	61
Cleveland	4	463	38	286	62
Columbus	3	220	57	69	31
Dallas	1	94	24	18	19
Denver	2	290	90	122	42
Des Moines	2	146	75	[a]35	24
Detroit	4	771	38	446	58
Duluth	2	95	46	65	68
Fort Worth	1	103	46	36	35
Grand Rapids	1	164	67	43	26
Houston	1	78	15	70	90
Indianapolis	2	107	23	40	37
Kansas City, Mo	3	185	39	95	51
Los Angeles	3	479	17	335	70
Louisville	1	114	30	41	36
Milwaukee	2	277	36	93	34
Minneapolis	3	378	76	158	42
Newark	1	106	25	44	42
New Orleans	2	200	40	31	16
Omaha	2	168	68	48	29
Pittsburgh	6	709	50	533	75
Providence	1	66	26	33	50
Richmond	2	110	41	23	21
St. Louis	3	259	24	118	46
St. Paul	2	308	99	81	26
San Francisco	3	391	62	92	24
Sioux City	2	[a]126	122	[a]17	13
Syracuse	1	422	193	334	79
Washington, D. C	2	226	34	143	63
Wichita	1	124	87	31	25

[a] Includes estimates.

would be interesting to know the number per 100,000 female population between the ages of 15 and 44 but 1940 population data by age and sex are not now available for the individual registration areas.

Fifty-one percent of the women were reported to be residents of the area in which the reporting agency was located. 4/ The proportion of resident women in each reporting area is shown in table 2 and is presented graphically in chart 2.

4/ Although fictitious addresses may sometimes be given by applicants for care, some checking of the reported distribution between residents and nonresidents in maternity homes has indicated that the reporting of this information, where examined, has been reasonably accurate.

Table 3.--Number of women admitted and discharged, and number of days' care provided to women in maternity homes, as reported by 84 agencies in 37 urban areas, 1940

Area	Number of agencies	Number of women			Number of days' care provided	Average length of stay[a]
		Admitted	Under care sometime during 1940	Discharged		
Total	84	7,981	9,942	7,931	747,137	94
Akron	1	46	62	45	4,844	105
Atlanta	1	55	79	48	9,056	174
Baltimore	1	51	73	51	8,829	173
Birmingham	1	100	126	94	10,701	110
Boston	5	484	604	466	46,549	98
Buffalo	4	429	510	428	32,123	75
Chicago	5	835	981	843	54,851	65
Cincinnati	3	243	328	245	25,136	103
Cleveland	4	342	463	358	43,654	125
Columbus	3	167	220	173	18,470	109
Dallas	1	69	94	75	12,148	169
Denver	2	211	290	225	[b]24,642	113
Des Moines	2	93	146	113	16,940	164
Detroit	4	608	771	618	59,149	96
Duluth	2	73	95	67	8,198	117
Fort Worth	1	85	103	84	6,818	80
Grand Rapids	1	135	164	137	10,855	80
Houston	1	61	78	59	5,901	98
Indianapolis	2	91	107	84	8,473	96
Kansas City Mo	3	140	185	141	17,405	123
Los Angeles	3	397	479	379	33,696	87
Louisville	1	88	114	88	9,599	109
Milwaukee	2	221	277	231	21,344	94
Minneapolis	3	304	378	286	30,428	103
Newark	1	80	106	77	9,899	125
New Orleans	2	159	200	149	18,808	122
Omaha	2	130	168	122	15,809	124
Pittsburgh	6	629	709	630	32,963	52
Providence	1	47	66	54	5,873	115
Richmond	2	76	110	77	13,410	174
St. Louis	3	208	259	195	19,835	98
St. Paul	2	247	308	233	25,307	105
San Francisco	3	308	391	308	31,891	104
Sioux City	2	97	[b]126	88	14,023	151
Syracuse	1	407	422	412	5,827	14
Washington, D. C	2	170	226	157	23,905	146
Wichita	1	95	124	91	9,778	105

[a] Computed by dividing the number of days' care provided during the year by half the sum of the women admitted and the women discharged.

[b] Includes estimates.

The proportion of resident women under care in the individual reporting areas ranged from 13 percent in Sioux City to 90 percent in Houston. The proportion was less than 25 percent in 6 areas; 25 to 49 percent in 16 areas; 50 to 74 percent in 9 areas; and 75 percent or more in the remaining 6 areas. The relatively low proportion of resident women cared for in a number of areas indicates that service is available to a geographic area which is State-wide or even wider in some instances.

Table 3, page 7 presents by area the num-

Table 4.--Number of women under care of maternity homes of specified type and percent of residents of the area, as reported by 84 agencies in 37 urban areas, 1940

Type of home	Number of agencies	Number of women under care		
		Total	Residing in reporting area	
			Number	Percent
Total..........	84	9,942	5,106	51
Catholic...........	19	3,051	2,071	68
Florence Crittenton.	18	1,799	855	48
Salvation Army......	21	3,101	1,333	43
Other types.........	26	1,991	847	43

ber of women admitted to and discharged from maternity homes during 1940, the total number of days' care provided, and the average length of stay.

The average length of stay in the several areas ranged from 174 days in Atlanta and Richmond, to 14 days in Syracuse, 5/ the next lowest being in Pittsburgh (52 days) and the next highest being in Baltimore (173 days). The average length of stay for the 37 areas was 94 days. The median length of stay was 105 days.

The data indicate a tendency toward a longer average length of stay in areas with a high proportion of nonresidents under care. For 5 areas reporting less than 25 percent of nonresidents the average length of stay was 57 days, for 9 areas reporting 25 to 49 percent of nonresidents it was 95 days, for 16 areas reporting 50 to 74 percent of nonresidents it was 100 days, and for 7 areas reporting 75 percent or more of nonresidents it was 130 days.

Types of Agencies

Of the 84 maternity homes included in this series, 19 were under the auspices of Catholic agencies, 18 were affiliated with the National Florence Crittenton Mission, and 21 were under the auspices of the Salvation Army of America. The remaining 26 homes were under the auspices of other religious denominations, nonsectarian boards, and, in one case, a public agency.

Table 4 shows that Catholic homes reported the largest proportion (68 percent) of resident women under care during 1940, Salvation Army and other types of homes each reported the smallest proportion (43 percent), and Florence Crittenton homes reported 48 percent. Examination of reports from individual agencies of these types,

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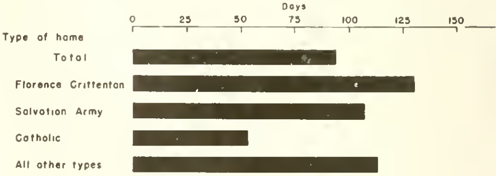
5/ The reporting agency in Syracuse is considered locally as a maternity home, although the average length of stay would indicate that the care provided is hardly comparable with that of other reporting institutions.

CHART 3.—AVERAGE LENGTH OF STAY PER WOMAN UNDER CARE OF MATERNITY HOMES OF SPECIFIED TYPE AS REPORTED BY 84 AGENCIES IN 37 URBAN AREAS, 1940



however, reveals no consistency in the proportion of residents cared for; the proportion vared in Catholic homes from 16 to 100, in Florence Crittenton homes from 9 to 90, in Salvation Army homes from 16 to 76, and in homes of other types from 9 to 100.

Significant variations in the average length of stay are revealed when the reports of the various types of homes are analyzed. The average length of stay--130 days--was greater for Florence Crittenton homes than for agencies of any other type. The average length of stay for Salvation Army homes was 107 days, for Catholic homes, 53 days, 6/ and for all other homes, 113 days (chart 3).

6/ The shorter average length of stay in Catholic homes may be attributed in part to the fact that these homes customarily form a part of a comprehensive system of institutional care that permits transfer from one institution to another.

During 1940 agencies conducting day nurseries in 34 urban areas reported to the Bureau through the social-statistics project. Reports were received covering 150 day nurseries, operated by 133 agencies. Two day nurseries were operated by a public agency, all the rest being under private auspices.

Day nurseries were originally organized to provide day-time care to children of working mothers, but at present they are providing care for children who for social as well as economic reasons cannot receive ordinary parental care. In their programs many day nurseries are stressing an educational program as well as physical care of the children. These developments have made day nurseries, which are welfare agencies, less distinct from nursery schools, which are primarily educational agencies. This lack of sharp distinction is particularly true of day nurseries and those nursery schools that limit their service to, or include large groups of, children in underprivileged families. Eleven of the participating areas that consider this resemblance to be most important have tabulated and submitted data on emergency nursery schools financed by the Work Projects Administration. These figures are presented separately in the detail by area given at the end of this article. The Work Projects Administration nursery schools restrict their service to children of 2 to 4 years of age from needy families. Many private nursery schools of a related type, such as nursery schools conducted by some settlements, are not included in the reports, however. 1/

Trend in day-nursery care.

A recent estimate placed the total number of day nurseries in the country at 600. 2/ Ten years earlier the number was placed at 800 in an estimate made by the 1930 White House Conference. 3/ Difficulties in defining precisely the agencies to be included in this field and the difficulty of reaching the many small day nurseries, together with the different bases used in making estimates could undoubtedly have had an effect on these figures, but it seems clear that a considerable decrease did occur in this period.

During recent years the staff of the Children's Bureau social-statistics project has made a special effort to obtain complete lists of agencies operating in the various welfare fields. A comparison of these lists for 1940 from 27 urban areas can be made with comparable lists available for 1936 from the same areas. At the end of 1940

1/ It would appear to be advantageous, when ever welfare workers consider day nurseries and nursery schools, to recognize as a division of the nursery schools those that are designed primarily for the benefit of underprivileged children and that normally charge only a nominal fee if any. These schools, although chiefly educational in nature, are of particular interest to welfare workers. This division, it will be recalled, was used in the report of the 1930 White House Conference in its detailed report of day nurseries and nursery schools where part of the agencies were classified as "relief nursery schools" (Report of the Committee on the Infant and Preschool Child).

2/ Social Work Year Book, 1941, p. 108. Russell Sage Foundation, New York, 1941.

3/ White House Conference on Child Health and Protection: Nursery Education, p. 7. Century Co. /Now D. Appleton-Century Co./, New York, 1931.

these areas reported 111 day nurseries in operation, all of which would probably be included in the above estimate of 600 for the country as a whole. In 1936 the comparable figure was 114 in operation. Since 1936, 11 day nurseries in these areas were reported to have been closed or reorganized as nursery schools, and [illegible] day nurseries had been started.

In terms of children enrolled, incomplete data available through reports of the social-statistics project for the past 11 years indicate a decline of more than one-fourth from 1929 to 1933; but since that time there has been little change.

Monthly changes in enrollment and total days' care.

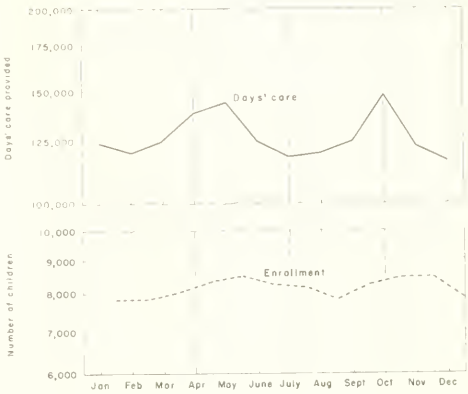
The monthly fluctuations in enrollment during 1940 and the total number of days' care provided by the 150 day nurseries reporting during 1940 are shown in table 1 and chart 1. In terms of enrollment the high point was reached in May (8,507), although the figure was only slightly above that for November. The enrollments recorded in these highest months were less than 10 percent above the lowest figures, recorded in January (7,824) and August (7,830).

Table 1.—Number of children enrolled at end of each month and days' care provided in 150 day nurseries in 34 urban areas, January to December 1940

Month	Enrollment	Days' care provided
January.................	7,824	123,233
February................	7,847	119,843
March...................	8,040	124,867
April...................	8,352	137,393
May.....................	8,507	143,098
June....................	8,254	124,618
July....................	8,189	118,101
August..................	7,830	119,612
September...............	8,247	124,444
October.................	8,450	146,793
November................	8,464	122,037
December................	7,887	115,994

The changes from month to month in total days' care provided were more marked. May was the second highest month, but after a drop during the summer season the total days' care provided rose to a peak of 146,793 in October. The holidays during November and December are reflected in the sharp decreases revealed by reports for those months. The fact that the reports have not been corrected for differences in the length of months accounts for the slight decrease shown from January to February in days' care provided.

CHART 1.—CHILDREN ENROLLED AT END OF EACH MONTH IN 150 DAY NURSERIES, AND DAYS' CARE PROVIDED, JANUARY-DECEMBER 1940



Care provided during October.

Data reported for October, the month in which the greatest number of days' care was provided, have been analyzed further in table 2, where figures for the individual urban area are

Table 2.—Care provided by 150 day nurseries in 34 urban areas, October 1940

Urban area	Agencies reporting	Day nurseries providing care	Children enrolled at end of month	Children enrolled per day nursery	Children attending at sometime during month	Days' care provided during month	Days' care per child attending	Children enrolled as rate per 100,000 population[a]
Total	133	150	8,450	56	8,372	146,793	18	36
Atlanta	4	6	564	94	434	7,939	18	118
Baltimore	4	4	247	62	262	5,096	19	29
Birmingham	5	5	278	56	188	3,657	19	60
Buffalo	1	1	72	72	66	861	13	9
Chicago	20	20	1,108	55	1,142	19,863	17	30
Cincinnati	9	9	262	29	280	4,726	17	42
Cleveland	4	8	489	61	517	8,568	17	40
Columbus	5	5	274	55	262	4,151	16	70
Dallas	2	4	164	41	184	2,902	16	41
Dayton	1	1	46	46	41	377	9	16
Denver	4	4	290	73	305	5,447	18	90
Detroit	2	2	69	35	68	1,405	21	3
Fort Worth	2	4	136	34	136	3,217	24	60
Hartford	1	1	62	62	65	1,105	17	25
Houston	2	3	57	19	78	1,443	19	11
Indianapolis	2	2	217	109	223	3,244	15	47
Kansas City, Mo	5	6	207	35	218	3,894	18	43
Los Angeles	10	11	637	58	630	11,177	18	23
Louisville	2	2	82	41	73	949	13	21
Milwaukee	1	1	48	48	53	861	16	6
Minneapolis	2	2	63	32	65	1,337	21	13
Newark	7	7	505	72	524	8,854	17	135
New Haven	2	3	241	80	226	4,517	20	108
New Orleans	6	6	327	55	284	6,094	21	66
Omaha	1	1	85	85	85	1,637	19	34
Pittsburgh	4	4	122	31	121	1,830	15	9
Providence	6	6	317	53	336	6,184	18	125
Richmond	2	2	55	28	47	853	18	21
St. Louis	7	7	559	80	592	9,931	17	51
St. Paul	2	2	159	80	168	3,186	19	51
San Francisco	4	7	492	70	505	8,342	17	78
Sioux City	2	2	132	66	119	1,922	16	127
Springfield, Mass	1	1	30	30	33	437	13	17
Wichita	1	1	54	54	42	787	19	38

Related data pertaining to Work Projects Administration nursery schools as reported by 11 urban areas, October 1940

Urban area	Agencies reporting	Nursery schools providing care	Children enrolled at end of month	Children enrolled per nursery school	Children attending at some time during month	Days' care provided during month	Days' care per child attending
Akron	1	3	61	20	61	1,393	23
Atlanta	2	6	136	23	145	2,309	16
Birmingham	1	9	293	33	293	4,840	17
Dallas	1	2	123	62	111	1,193	11
Houston	1	4	262	66	239	3,985	17
Indianapolis	1	4	80	20	84	1,466	17
Kansas City, Mo	1	5	169	34	181	2,713	15
Louisville	1	6	176	29	139	2,905	21
San Francisco	1	6	184	31	186	4,232	23
Springfield, Mass	1	6	190	32	189	4,347	23
Wichita	1	2	40	20	42	829	20

[a] Population according to 1940 census.

presented. At the end of that month 8,450 children were enrolled by the 150 day nurseries, an average of 56 children per nursery.

The total number of children enrolled at the end of the month was only slightly greater than the number who attended at some time during the month (8,372). The number of children attending day nurseries on any one day is generally expected to equal only about four-fifths of the total enrollment, 4/ but because of temporary absences and such changes as occur in enrollment from month to month the number of children who attend at some time during the month is found to approach the total enrollment.

The 146,793 days' care provided during the month amounted to 18 days per child attending at some time during the month.

Less than 10 percent of the days' care reported by the day nurseries were for part days. It should be noted, however, that a part day refers here to a part of that time during which the nursery was open. Thus, for example, if the nursery is open for only part of the day, a full day's attendance is counted. Also, older children coming to the day nursery for lunch and after school are counted as receiving a full day's care.

Variations by area.

The variations in the volume of day-nursery service from area to area were extreme. Chicago reported 1,108 children enrolled at the end of October 1940, whereas 12 of the 34 areas reported less than 100 children enrolled. 5/

To remove the effect of size of city upon these variations, the number of children under care has been compared to the 1940 population of the cities. 6/ The average for all areas was 36 children enrolled in day nurseries per 100,000 persons in the general population. Only 4 of the 34 areas, however, had ratios of 30 to 40. Nine of the areas had ratios of more than 65, and 6 had ratios of 15 or less, again indicating the wide differences in the volume of service found. 7/

4/ Id., p. 59.

5/ 45 areas participate in the Children's Bureau social-statistics project. Of the 11 not represented by these statistics, 6 reported that no day nursery was in operation.

6/ Although the importance of differences among these areas in the proportion of children to the general population is recognized, in the absense of child-population data for 1940 general-population data for 1940 have been used rather than child-population data for 1930.

7/ In all but two of the urban areas reports are received from all day nurseries. These two areas have estimated that their reports cover the following proportion of the total service: Chicago, 90 percent; and Newark, 87 percent. In arriving at these ratios allowances have been made for these estimates of services rendered but not covered by the reports.

The SOCIAL-STATISTICS SUPPLEMENT is issued by the Children's Bureau four times a year, in connection with the Bureau's monthly publication, THE CHILD.

The purpose of the supplement is to make available for general use summaries of current social statistics related to child welfare, prepared by the Bureau's Division of Statistical Research. While material presented in the supplement will be based largely on reports forwarded by health and social agencies in connection with the Bureau's project for the registration of social statistics, closely related material from other sources will also appear from time to time.

Published under authority of Public Resolution No. 57, approved May 11, 1922 (42 Stat. 541), as amended by section 307 Public Act 212, approved June 30, 1932 (47 Stat. 409). This publication approved by the Director, Bureau of the Budget, May 12, 1936.

U. S. GOVERNMENT PRINTING OFFICE : 1941 — O - 403294

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